Zdrav*Reform*
Russia
Final Report to
USAID Moscow

Zdrav*Reform*
Здрав*Реформ*

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July 31, 1997

Becky Copeland
Office of Environment and Health
U.S. Agency for International Development
Moscow, Russia

Dear Becky,

We are pleased to submit for your review our Final Report for the **Russia Zdrav*Reform* Program.**

During this three year program, funded in late 1993 by USAID and launched by Abt Associates Inc. during the early months of 1994, Zdrav*Reform* provided collaborative support and innovative approaches to health financing and health care organization and management reform in selected oblasts of the Russian Federation. It worked with Russian health care experts to design, implement, evaluate and refine initiatives that enhanced the efficiency, equitable access, sustainability and quality of health care, and then worked within the limited budget to disseminate the resulting achievements and lessons learned around Russia. Dissemination activities of the ideas and products of Zdrav*Reform* will be continued through the follow-on contract being administered by Kaiser Permanente International.

Activities under the Zdrav*Reform* Program were catalyzed in 1995 when ZRP operated at its peak with a staff of 34, of which 7 were US citizens, in a Country Office in Moscow and site offices in Novosibirsk, Tomsk, Kemerovo, and Barnaul. There have been over 104 Russian experts performing various contracted work to design, develop and implement over 80 important pilot projects. These pilot projects and 38 grantee organizations have served communities with over 26 million people.

In affirmation of the large impact we feel the project has made to the Russian healthcare system, the primary conclusion of the independent evaluation of the Zdrav*Reform* Program was "that the project has been extremely successful in helping shape change, and the technical assistance provided under the project has had a noticeably high marginal return."

This report begins with an overview of the program, describing the background of the Russian health sector, the goal of Zdrav*Reform*, accomplishments achieved, constraints to achieving the goal, strategies employed, and sustainability. The paper then goes on to discuss the technical results by functional area, the training provided, and the Small Grants Program. Technical and Grant Appendices are presented in separate volumes.

Sincerely yours,

Ellen R. Bobronnikov
Russia Grants Manager

cc: Nancy Pielemeier, PhD, ZRP Bethesda

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I OVERVIEW

A. Background

Despite the breakup of the former Soviet Union, the health sector in Russia largely continues to resemble the vision and planning of the former Soviet regime. The health sector in Russia is clearly in a period of transition, moving from a centrally planned and financed system based on state ownership to a regionally oriented system based on health insurance principles in which financing and provision of care are separated. However, the residual conditions of the healthcare system touched upon below and the worsening state of health of the Russian population make it clear that significant further reform is necessary.

The health sector continues to reflect the rational planning and hierarchical structure found throughout the former Soviet Union's health system. *In theory*, it is a highly integrated network, providing all necessary services to the entire population. In urban areas, each individual is assigned to a polyclinic and has a primary care physician practicing within the polyclinic; in rural areas, there is a basic health unit of one or more physician-extenders (e.g., feldshers or nurses) and some limited supply of medicines. Patients receive referrals to move to a higher level within the system. Depending on the seriousness and complexity of a patient's condition, he would be referred progressively to better equipped facilities.

In practice, however, the system has been replete with problems. In general, there is ***little consumer choice***, and there are few private solo practitioners or private clinics. Another area of continuing concern is ***the bias toward curative care over primary care***. Less than 15 percent of the country's physicians provide primary care (compared with about 70 percent in Germany; with 56 percent in Canada).

Historically, the system has been financed in a centralized "top-down" bureaucratic allocation process, based on national budgets formulated and passed by the central legislative and policymaking bodies. This, in part, has lead to ***the severe problems related to total funding for health care***. Traditionally, the health sector has been viewed as a "nonproductive" service sector, and funded only with residual funds available after other programs are funded. Furthermore, the share of the country's GDP devoted to health has declined precipitously since the 1980s, and the economic decline that Russia has suffered over the past several years has contributed further to reduced locally generated tax revenues, a portion of which would eventually be spent on health. An emerging funding crisis in health services has resulted.

In the late 1980s, it became clear that poor performance and declining health outcomes of the Russian health sector were caused not only by underfunding, but by ***inadequate management of health care resources*** (Sheiman, 1994). Chronic underfunding was coupled with poor and often perverse incentives in the use of funds for services. The traditional Soviet approach to health care delivery did not encourage the efficient use of resources by providers. This was due in part to a system that allocated resources based on traditional central planning, production input measures, such as occupancy and numbers of staff and beds, rather than on the basis of actual services provided, the relative complexity of those services, or (ultimately) changes in health outcomes. For example, hospitals received and continue to receive budgets based on numbers of beds, which discourages hospitals to decrease excess bed capacity and cutback on other, associated hospital resources. The result has been too many hospitals, too many beds, and too many physicians generally.

Inappropriate incentives have also lead to the ***lack of efficiency of physicians practicing in the polyclinics***. Physician-care budgets are developed and are based on "capacity of the polyclinic" as measured by staff and *potential* numbers of visits. Polyclinics develop by increasing their numbers of low-paid, salaried physicians. The lack of competition and choice, as well as the lack of incentives to increase income, tends to encourage physicians to act as indifferent dispatchers who refer patients to hospitals (Sheiman, 1992). Referral rates to hospitals appear to run about 25-30 percent of first visits to polyclinics (Sheiman, 1994) relative to 8.6 percent in the United Kingdom, and 5.2 percent in the United States (Sandier, 1989). Hospital admission rates as a percent of population is 22 in

the Russian Federation relative to 16.2 on average for all OECD countries; this difference can be attributed in part to the higher referral rate.

Over the last five to ten years, ***socioeconomic and environmental problems have created additional strains***, both to the health of the population-as measured by morbidity and mortality health status indicators-as well as by assessment of the health care system itself. Based on 1993 statistics, the Russian Federation does poorly on key health status indicators compared to an average of 24 OECD countries. For example, OECD infant mortality rate per 1,000 population is 9.7 compared to 20 in the Russian Federation; OECD crude death rate is 9 compared to 11 in Russia. In health care delivery indicators, OECD has 2.4 physicians per 1,000 population whereas the Russian Federation has 4.69; 9.2 hospital beds per 1,000 population compared to 13.8 in Russia; and OECD spends 46.1 percent of health sector riding on hospitals compared to 57 percent in the Russian Federation, with 8 percent of the GDP allocated to health care versus 3 percent in the Russian Federation. Overall, a relatively high share of resources, nearly 60 percent, is allocated to more expensive in-patient care (IBTCI, 1994). A comparative indicator for OECD countries-hospital use plus long-term care-is around 45-50 percent.

In summary, some of the problems facing the Russian healthcare system include i) little consumer choice, ii) a bias toward curative care over primary care, iii) inadequate funding for health care, and iv) inappropriate incentives leading to poor management of health care resources and a high referral rate from polyclinics to hospitals. These factors, taken in combination with the further decline in the health status of the Russian people due to socioeconomic and environmental causes, demonstrate the need for reforms and the complex challenge of supporting new reform initiatives.

B. Project Goal

The **Goal** of the Zdrav*Reform* project has been to improve the health of the population in support of economic and democratic development by increasing economic efficiencies, quality of care and provider choice in the Russian Federation through market-oriented reforms of the health financing and service delivery system, while protecting universal access to health care.

In striving to meet its overall goal, the Zdrav*Reform* Russia effort has encouraged the following intermediate results:

⇒ greater decentralization of health care delivery authorities and responsibilities to local health are providers, which enable them to more responsively meet the needs of consumers;

⇒ a shift to more cost-effective medical interventions;

⇒ increased internal efficiencies by health care providers and service delivery systems;

⇒ greater diversity and competition among service providers; increased consumer choice;

⇒ greater equity in the allocation and utilization of health care resources; and

⇒ ultimately, better access for Russians to quality health care.

Because of the short project timeframe, objectively verifying goal achievement is somewhat challenging. Institutional records and special surveys have been utilized in the geographical areas impacted by the project to assess the extent to which the project has contributed to improvements in health status relative to recent health status trends, and the extent to which project working models have contributed to economic and democratic development.

The achievement of the goal will be shown in this report by descriptions of the established and functioning health care reform working models that demonstrate, and therefore serve to promote, reforms in financing, service delivery and institutional management. Through site visits, project and institutional records, materials and reports, progress in achieving the project goal has been monitored and assessed.

C. Summary of Outputs Achieved in Meeting Project Goal

To achieve the project goal, the following topics have been specifically addressed through designated project outputs:

1. The legal/regulatory framework needed for health care reform;
2. The quality of health care and flow to improve it;
3. New and improved financing methods to pay providers and ways to better organize and manage scarce resources;
4. New and more sophisticated computerized information systems needed to support the above; and
5. Dissemination and roll out of successfully demonstrated reform working models and systems, to facilitate and promote replication elsewhere in the Russian Federation,

All of the development activities and subactivities described in this report were designed to achieve one or more of the five outputs defined below. (Refer to Section II for descriptions of the work performed in each of the tasks under these five output areas). The achievement of outputs has been monitored and reported according to the indicators that are listed in the table following this section.

Output 1: Legal/Regulatory Framework Output: *Russian leaders have been informed about the legal and regulatory framework required to support health care reform, and the economic and social justifications for adopting new and improved laws and regulations.*

The achievement of this output required the orientation, via various discussion papers, articles and seminars, of Russian leaders from the federal level and many oblasts in legal/regulatory framework requirements of health care reform, including the economic and social justifications for such changes. Also, at the direction of USAID Moscow, project advisors have provided input to policy development processes that has contributed to the design of Federal and Oblast level health care reform laws and regulations.

Output 2: Quality of Care Output: *Successful demonstration of institutionalized working models for the improvement in quality of health care has been achieved through two major initiatives; one focused on hospitals, the other on polyclinics.*

Output achievement has been verified through site visits, institutional and project records, reports and materials, and will consist of:

1. Fourteen working models for quality improvement within hospitals have been established and are functioning, with documented quality of care improvements and lessons learned; five hospital quality management councils have been established and functioning with authorizing documents and lessons learned; five hospital quality improvement departments have been established and functioning, with authorizing documents and lessons learned; 11 quality improvement projects were sanctioned by the quality management Councils. Quality improvement targets included: a 10 percent reduction in hospital infection rates, a 15 percent reduction in complication rates associated with normal vaginal delivery, and a 20 percent increase in-patient satisfaction rates. These targets were met. In fact, the reduction in hospital infection rates was 30%.

2. Eleven polyclinics are utilizing institutions and sustainable ambulatory quality of care indicators, with documented improvements in the quality of care and lessons learned.

3. 300 physicians have been trained in the use of indicators and 600,000 consumers are eligible to receive care provided within the improved system.

Output 3: Financing and Resource Management Output: *Successful demonstration of working models for new and improved systems of health care financing and resource management.*

Output achievement has been verified through site visits, institutional and project records, reports and materials, and consists of:

1. Nine institutionalized and sustainable working models have been established and are functioning. They demonstrate new and improved cost accounting and resource management systems, with lessons learned documented. Over 80 cost accountants and financial managers were trained to achieve this output.

Output 4: Health Management Information System Output: *Successful demonstration of new health management information system working models that support modern, information-driven decision-making practices among health care service providers and managers.*

Output achievement will be verified by site inspection visits, institutional and project records and reports and materials, and will consist of:

1. 2,000 CD's were produced and distributed containing 7,000 pages of Russian text and graphics reflecting best management practices of the US health care industry; and 400 health care leaders and managers were trained in accessing and utilizing the electronic library.

2. Two health management information systems were each installed in several sites and are functioning, with documented lessons learned. The Territorial Fund Information Systems working model is expected to increase the premium collection rate by 10 percent, decrease the policy generation turnaround time by 50 percent, and increase patient demographic and clinical history information available at point of service by 25 percent. The Clinical Patient Record Systems support care to approximately 200,000 people.

3. Management process standards were set and met for:
   - Premium rate setting
   - Physician practice profiles
   - New technology purchase decisions
   - Strategic budget planning.

Also, 25 computer systems specialists and users were trained in system operations, and 50 health system managers and health care providers were trained in utilizing integrated health management information system data for improved decision making in integrated health care management.

Output 5: Dissemination and Roll Out Output: *Russian leaders and health care system planners and managers were informed about health care working models and have the materials and tools to replicate reform successes elsewhere in the Russian federation.*

Output achievement were verified through delivery of materials and tools, and through review of project records and reports, and consist of:

1. Five hundred to one thousand copies of each of twenty-eight technical and grant products will be printed for dissemination. (See Appendix 10 for list of documents to be printed) These documents cover topics including contract development, development of general practices, financial modeling, cost accounting, payment methods, quality improvement, as well as others. Additionally, 75 hard copies of 22 ZRP documents and 250 electronic copies of 19 ZRP documents were distributed at the Russia Dissemination Conference in November 1996. (See Appendix 11 for list of documents distributed at conference)

2. 500 Russian leaders and health care planners and managers were oriented about health care reform working models and trained in utilization of materials and tools; 250 leaders and managers were oriented on quality improvement, financial management and cost accounting and health fund management information systems; 75 leaders and managers were oriented on private practice development; and 100 leaders and managers were oriented on provider contracting;

3. A professional association was supported to periodically publish and distribute information on health care reform working models, and related lessons learned, and sponsored annual national conferences in 1995 and 1996, to stimulate information exchange and dialogue on health care reform issues.

Indicators

In order to help gauge the overall effects of the Zdrav*Reform* Program, a number of indicators were defined and monitored regularly in the Siberian geographical focus areas. Data collectors in each of the four oblasts gathered data on the following indicators:

1. Share of actual allocations to public health facilities, provided through contracts with the funding sources,
2. Outpatient care expenditures as a percentage in total health expenditures,
3. Share of primary care physicians,
4. Referral rate,
5. Number of admissions,
6. Number of calls to emergency care stations,
7. Scope of disease prevention measures,
8. Hospital bed capacity, and
9. Number of operational day care centers.

Data on these indicators was first prepared in the summer of 1995. Annual data for each oblast was presented for 1994, and semi-annual data was presented for each of the pilot sites (in order to get a more accurate picture of the direct effects of the program) for the first half of 1995. Contracts were then made with the data gatherers to collect the information on a quarterly basis, however in some cases, because of various circumstances, data for some quarters were not available. The final data gathered for ZRP was for 1st quarter 1996 for all sites except Tomsk, which also presented data for 2nd and 3rd quarters 1996. A summary of the trends of indicators between 1994 and 1996 is presented in Exhibit 1 below. The complete data is in Appendix 2.

Analysis of the Results Shown by the Data

The above indicators are quite powerful and, as can be seen in Exhibit 1, they encourage an overall assessment of a positive program impact. Some of the indicators and actual numbers are consistent with substantial organizational and behavioral changes in the pilot sites across the 4 oblasts.

Initially, the indicators show that levels of funding remain uncertain and quite volatile, with significant swings in both directions in some cases. This might be due to public budget allocation problems or issues related to implementation of the compulsory health insurance system enacted in 1993. Health insurance laws of 1991 and 1993 called for a new 3.6% employer payroll tax and envisaged a pooling of these revenues with public budget moneys. However, difficulties have persisted in compliance with payment of the payroll tax, budget allocations due to economic volatility, and with pooling of resources. These difficulties were largely beyond the scope of the project.

The uncertainty of funding levels shifts a greater emphasis to areas related to improving efficiency of how resources are used, and to improving the effectiveness of care delivered. The numbers suggest positive changes in these areas, and are generally encouraging.

Many sites show gains in allocative efficiency of existing revenues or resources, as measured on several indicators:

- numbers of primary care physicians have increased in several sites;
- some of the sites show significant gains in the percentage of expenditures going to more cost-effective outpatient settings;
- numbers of referrals to more expensive specialty and inpatient care have dropped across several pilot sites; and,
- numbers of admissions per capita appear to almost uniformly have dropped across all sites. At some pilot sites, admissions have dropped as much as 39 percent.

In general, this suggests a shift from old-style Soviet healthcare which emphasized specialty care and more expensive inpatient services. Instead, organizational changes, changes in quality management, and changes in financial incentives are moving these sites toward a more cost-effective

style of care which emphasizes increase use of primary care and outpatient care.

This shift in use of resources was reflected in changes in sector capacity related to the number of hospital and post-acute beds. The more expensive hospital beds were being reduced, and (at least for Kemerovo) suggest these were being substituted with less intensive, less expensive sub-acute day care beds. Resources saved related to cuts in hospital beds, however, will be most pronounced when coupled with the closing of entire wings or hospitals. If bed changes do not encourage facility closings, fixed costs may not significantly decrease. The program did not collect data on facility or wing closings.

The numbers of/use of emergency services dropped in almost all sites uniformly over time. Emergency services often substitute for needed services denied or deferred. Services could be deferred due to lack of patient initiative or due to barriers in access to care. Emergency services often were used in the old Soviet system as a way to bypass the referral system, and acted as a more expensive substitute for outpatient polyclinic care. Again, the numbers are suggestive of increased use of appropriate and timely care, and more cost-effective care.

These generally positive changes across sites were not uniform. The variations are not surprising and to be expected, and reflect a number of factors both program related and other. In some sites in Kemerovo these indicators appear to move in the wrong direction. Why these sites show problems is not clear, and the information provided here is limited and does not allow any conclusive analysis. Specific site-by-site profiles looking at payment system design and coordination of incentives across settings (see ZRP profiles by Sheiman (1996), for example) might provide some further analysis and insight for the reader, especially when linked with specific pilot site data and trends.

Finally, indicators do not suggest uniform increases in preventive care for pregnant women or children which is disappointing. In most sites there were increases in these services, but there were reported decreases in 2 of 4 oblasts -- Tomsk and Altai Krai. Decreases were seen for both preventive care for pregnant women and pre-school children.

These sites in Tomsk and Altai Krai designed and implemented types of capitation-related schemes. These schemes in other countries have been associated with “skimping on care” under some circumstances and these designs may have discouraged utilization of some services in the short run. Follow-up activities might carefully investigate these drops. Further analysis may identify alternative reasons for these drops. Or, if indeed associated with the design features, these pilot sites could alter either incentives or quality improvement initiatives to better assure continued levels of these services. For example, in some countries, “priority services” (which often include preventive services) are “carved-out” of the capitation payment. These carve-outs are then subject to fee-for-service or special bonus payment provisions designed to protect access and utilization of these services and to promote these as appropriate.

Exhibit 1 - Performance Under Zdrav*Reform* Between 1994 and 1996

INDICATORS	1. Share of actual allocations to public health facilities, provided through contracts with the funding source (Health Committees and insurance companies), percentage	2. Outpatient care expenditures as a percentage in total health expenditures in pilot sites covered by Zdrav*Reform*	3. Share of primary care physicians in the total number of physicians in pilot sites, percentage	4. Referral rate in pilot sites, percentage	5. Number of admissions per 1,000 of the population	6. Number of calls to emergency care stations per 1,000 of the population	7. Scope of disease prevention measures, percentage of groups of population: - pregnant women - pre-school children - schoolchildren			8. Hospital bed capacity in the pilot sites per 10,000 of the population	9. Number of operational day care centers in the pilot sites
Altai Krai											
	Increase of 4%	Increase in 6 % in 3 of the sites, and Decrease in 3 % in other 3 sites	Increase of 3% across all sites	Decrease of 2%	Decrease of 3%	Decrease of 5%	1% inc	9% dec	15% dec	Decrease of 8%	the number of home care units remained unchanged.
Tomsk											
	Small increase in 2 of the sites, and decrease in 3rd site.	Small decrease in 2 of the sites.	Very little change - small increase in 2 of the sites, and increase in 3rd site.	All 3 sites decreased between 3% and 8%.	All 3 sites decreased between 10% and 38%.	All 3 sites decreased between 15% and 37%.	All sites dec 3% -10%.	NA	NA	1 site decreased by 8 %, others remained unchanged	Data is sparse, 1 of the sites decreased by 1.
Kemerovo											
	The overall change among all of the pilot sites was negligible. 6 of the sites had increases of 4-26%, and 7 of the sites had decreases of 6-19%.	There was an overall increase by 7% among the pilot sites. 5 of the sites had increases of 10-45%, 4 of the sites had decreases of 6-26%. and 4 of the sites remained unchanged.	There was an overall increase by 1% among the pilot sites. 6 of the sites had increases of 3-21%, and 7 of the sites had decreases of 1-13%.	There was an overall increase by 5% among the pilot sites. 4 of the sites had decreases of 0.2-39%, and 9 of the sites had increases of 0.6-32%.	There was an overall decrease by 50%. 12 of the 13 sites decreased by 31-92%.	There was an overall decrease by 35%. 8 of the 13 sites decreased by 16-55%. 5 of the sites do not have the data available.	Overall Inc by 22%.	NA	NA	There was an overall decrease by 6%. 5 of the sites decreased by 0.7-20%., 2 of the sites increased by 2%, 1 remained unchanged, and 5 of the sites do not have the data available.	There was a four-fold increase in the number of operational day care centers.
Novosibirsk											
	Increase of 8%	Increase of 5%	There was a large decrease (28%) in Q3 1995 (possible that initial data mistakenly represented entire oblast),and a 1% decrease by 1996.	Decrease of 25%	There was an overall decreasing trend, the number of admissions varied greatly by quarter.	There was a large decrease (81%) in Q3 1995 (possible that initial data mistakenly represented entire oblast),and a 12% increase by 1996.	1% inc	3% inc	varies by quarter	The overall change was negligible.	the number of home care units remained unchanged.

D. Constraints to Achieving Project Goal and Outputs

A number of challenges existed in achieving the project goal and outputs. The following 12 key constraints were addressed in the formulation of project strategies and in the design of project activities:

1. The existence of legislation and formal policies affecting health care reform, which are often ambiguous or contradictory;

2. Serious underfunding of the public health sector compounded by hospital dominated resource allocations;

3. The unclear definition of respective roles and relationships of health committees and the territorial health insurance funds;

4. The absence of business management skills among Territorial Health Department and Territorial Fund administrators;

5. Weak or nonexistent financial cost accounting systems and financial management practices to support alternative payment methods and efficiency monitoring;

6. An excessive supply of labor, particularly specialist physicians,

7. The underdeveloped experience and interest in performance-based methods of payment that was common in majority of physicians due to various causes, including unofficial (extra legal) health care activities;

8. General resistance to centralized decision making and directives, which are necessary on a limited scale at the oblast and national levels to set standards for quality of care and resource management;

9. The absence of an adequate telecommunications infrastructure to support proposed introduction of new and sophisticated computer-linked systems;

10. Policy leader impatience for tangible results and the relatively short period of time available to design and implement sustainable pilot projects successfully to demonstrate the value of reforms;

11. Public hesitancy to pay directly for system changes until benefits are more visible; and

12. Public reluctance to modify lifestyles that contribute to poor health status, and the ineffectiveness of existing health care delivery systems in influencing behavioral changes in consumers.

E. Project Strategies

The Zdrav*Reform* Project was designed to achieve improved health sector performance and health status improvement while minimizing the negative impact of the constraints outlined above. The following general strategies guided project design, and helped to ensure achievement of proposed outputs.

Russian/American Partnership

To effectively assist Russian leaders in facilitating reform efforts that are successful and sustainable, the project clearly recognized its role in forming a supportive partnership with local and federal health sector leaders. Russian leaders and counterparts provided the direction and set the pace in designing, implementing and assessing the results of project activities. Only through a highly collaborative approach, particularly onsite at the oblast and local institutional levels, can effective and sustainable institutional change and development occur. Consequently, project activities were designed to occur at the closest possible location to development sites, consistent with the output achievements sought.

Flexibility

The Russian health care system, which already is in major transition, undoubtedly will undergo many additional shifts that may vary greatly from one geographic location to another, given the decentralization policies of the federal government. The shifting political, economic and social conditions, and the growing knowledge of Russian health care reformers, due partly to this project, occasionally require adjustments in this project design, and in how it was implemented. The *ZdravReform* project staff remained flexible in adapting quickly to changing conditions and demands, by revising project activity implementation plans and budgets as needed to keep pace with Russian reform requirements.

Linkages of People and Institutions

A key strategy for facilitating the education and improvement of Russian health care reform leaders is to expose them to a broad range of U.S. and international experiences in health care financing and service delivery. People-to-people and institution-to-institution linkages in the past have proven to be effective methods to facilitate growth in understanding and cooperation. Consequently, this approach has been continued in coordination with other USAID and other projects that have a similar strategy. Russian public officials from the various levels of government were linked to public and private sector health care leaders elsewhere, as were emerging Russian private sector leaders. Russian health service delivery institutions and related educational and professional institutions and organizations were linked to appropriate institutions and organizations as well. Information exchange and two-way dialogue on health care reform issues and solutions has benefited both countries, since Americans often have as much to learn from the Russian experience as Russians do from the American experience. The significant mutual benefits to be gained by both societies should result in long-term collaborative relationships that extend well beyond this project.

Sector and Regional Focus

Because of limited project resources (relative to Russia's overall resource needs to support health care reform), the project concentrated most of its efforts and resources on the reform-oriented region of Siberia, specifically Altai Krai, Novosibirsk, Tomsk and Kemerovo oblasts. Targeted grants and selected technical assistance activities also took place in other oblasts, including Yarolslavl, Tver, Smolensk, Kaluga, Tula, Rostov and Vladivostok as well as others. All of these oblasts were open to reform and receptive to testing working models designed, implemented and evaluated with project assistance. This strategy was intended to achieve maximum impact from USAID's contribution to health care reform in Russia, while also laying a sound foundation for longer term reform efforts countrywide.

Systems Approach and Integration

Successful health care reform requires a systems perspective and a comprehensive integrated approach to health care financing and delivery

that, for many health professionals, is an entirely new way of thinking. Balancing provider and consumer needs in changing economic, social and institutional settings to achieve major improvements in the efficiency and effectiveness of services, is a complex task. The project was designed specifically to introduce and demonstrate heath care delivery models that encourage compatibility among quality of care reform, financing and resource management reform and information-driven decision-making practices requiring new and far more sophisticated health management information systems than heretofore have existed.

To design and implement this overall effort successfully required a well coordinated and balanced approach in which no one system component dominates or distorts the balance. All components were to be interdependent and mutually supportive. This required close collaboration between technical advisors and counterparts, and between the project staff and participating institutions; with most design and implementation decision making occurring at or near implementation sites.

Direct and Indirect Incentives

The project relied on a market orientation to health system planning and operations management. Human and institutional incentives offer consumers and providers greater freedom of choice and convert supply and demand dynamics into improved quality of care and increased financial resources to support improved quality of care.

Serious underfunding of health services currently provides a receptive environment in which to utilize direct economic incentives to change the behavior of health care providers and service delivery institutions. New and expanded sources of revenue can be utilized to reward desired behavioral changes. Greater efficiencies in resource utilization also can be obtained if the benefits gained through greater efficiencies are partly shared with those who create and maintain them.

Similarly, job satisfaction and professional status incentives were utilized to facilitate the implementation of reform measures among providers, supervisors and managers. Improvements in the morale and motivation of providers and other health care facility staff should stimulate greater consumer satisfaction with more appropriate demand. As personal and family costs become associated with health care, consumers will become more aware about their own responsibility for personal and family health. With expanded choice of providers and payment, consumers are expected to adjust their service utilization to the most responsive providers; providers will expect reasonable compensation, but will have to compete for institutional and personal buyers of care to enhance their income and professional stature.

The project was designed to utilize minimal resources to demonstrate how market forces can be used to achieve improvements in health care financing and service delivery. Enhanced financing and delivery systems should contribute to enhanced overall system performance, and ultimately health status improvements.

The project fully recognized the great amount of work and progress toward reform that has already been achieved in the Russian Federation and the extensive talent, creative energy and leadership that exists in Russia to achieve major reforms. The Small Grants component of the project was designed to catalyze and facilitate such continued reform initiatives by identifying and funding 38 important innovation projects. These innovation projects contributed to the overall Zdrav*Reform* project goal and purpose, while also demonstrating how market-oriented competitiveness among potential grantees can generate exemplary efforts in health care reform. Grant-funded development initiatives were also intended to demonstrate the value of providing greater freedom in implementing health care reform, and to encourage more informed local citizens and civic leaders about their role in reforms.

Local Versus Expatriate Technical Assistance Utilization

First priority was be given to utilizing Russian specialists whenever possible. Expatriate specialists were only utilized when highly specialized expertise unavailable in Russia was required, and/or when there was a need to import Western health care reform methods and technologies for adaptation and testing in Russia. This approach to priority selection of

technical advisors is consistent with the partnership strategy described above and the commitment to build Russian health sector technical assistance capabilities while utilizing Russian specialists to assist with designing and implementing the project. The high costs of utilizing expatriate technical specialists, relative to the cost of Russian specialists, was another major consideration. In seeking to achieve the largest possible development impact from limited project resources, every effort was made to select and utilize technical expertise on the basis of cost/value considerations.

Leveraging of Resources for Maximum Impact

USAID's contribution to Russian health care reform efforts was maximized through USAID-supported development initiatives that leveraged additional resources from Russian and international donor organizations to also support reform. The project was designed to stimulate and promote greater resource contributions by local and oblast governments, and donor agencies like the World Bank, which are more likely to expand source contributions if basic and receptive institutional frameworks are put into place.

The project also leveraged its own resources by restructuring the work of short-term TDY technical specialists from single into multipurpose visits, and by utilizing initial reform working model design and training materials, with appropriate adaptation, in phased design activities that occur later in other locales.

F. Project Sustainability

Sustainability of project-generated advances in health care reform was an essential objective of the project. The following approaches to financial and institutional sustainability were an integral part of the overall Zdrav*Reform* project:

1. Ensuring that there was a clear policy commitment and mandate at oblast and institutional levels for project initiatives that involved implementing, testing and demonstrating reform working models. Commitment was reflected in Cooperative Agreements with Russian Governmental Agencies: letters of agreement were signed with all six oblasts. The Ministry of Health's Public Health Research Institute and the Federal Fund will use their offices to distribute printed materials from the Working Models. The mandate was reflected in the extent to which the commitment was communicated to health care leaders and service delivery institutions in the oblast, and the extent to which host institutions contributed their share of the resources needed to implement, test, refine and institutionalize reform working models. Without such commitment and a mandate, project investments in health care reform could have been wasted.

2. The close collaboration between Russian partners and project staff in the design of project reform working models and the implementation of project working models within existing health system institutions helped ensure that changes in institutional functioning brought about by reform efforts remain in place after the project's end. Institutional change is neither done easily nor quickly, and normally requires extraordinary efforts and resources. However, after project reform working models are in place and functioning, extraordinary efforts and resources would be required to negate them. Thereafter, institutional change is expected to occur on an evolutionary basis as working model designs are further refined.

3. Additionally, cooperation with other USAID contractors has occurred to assure the full availability of Zdrav*Reform* materials to those contractors that will be working in Russia following the completion of this contract. The ZdravReform Team has coordinated very closely with KPI and AVANTA to provide them with all of our materials for dissemination. We have worked hard to accommodate their schedule to try to provide printed materials in time for their conferences, where they hope to disseminate these materials, and we have provided AVANTA with electronic versions of the documents in the event that the printed versions will not be ready in time.

4. Reform working models being designed and implemented by the project reflected an integrated approach to health care service delivery, financing and management. Consequently, each working model demonstration was designed to include as many of the institutional infrastructure elements that are needed to sustain it on a long-term basis. Working models in quality improvement, financing and resource management and health management information systems were fully compatible and mutually supportive, to reinforce sustainability within their respective institutional environments.

5. Both the project and host institutions contributed resources to support the design, implementation and testing of working models. Project resources supported the special nonrecurring startup, model testing and adjustment activities, whereas the host institution contributed the operational resources needed to sustain the working models initially and on a long-term basis. As previously indicated, major commitments of resources by host institutions to this reform effort, in some cases a greater contribution than the project made, indicate real commitment to sustainability.

6. During the collaborative processes of working model design, implementation and evaluation, counterparts further developed their skills in health care systems reform and gained from technology transfer. As a result, Russian partners have become even more self-sufficient in designing, implementing and evaluating health care reform efforts. Lessons learned from project experiences will not only be published and disseminated, but also will be incorporated in the minds and capabilities of Russian counterparts who can be expected to

continue successful reform efforts within their own institutions and as consultants to other institutions, thereby expanding opportunities for themselves and the health care reform movement in the Russian Federation. As a result of these considerations, the project intends that both its working models and the resulting accelerated reform movement will be fully sustainable.

7. Grants have been made to 16 Russian professional associations and management training organizations to distribute materials and develop managerial capability to use the results of the Working Models, (see Appendix G1 for a profile of grantees that will be instrumental in such dissemination activities).

8. A review article of the Zdrav*Reform* program's objectives, participants and results was developed and made available in English and Russian to all participants coming to Moscow for the Gore-Chernomyrdin Commission discussions in July 1996.

9. A Final Products matrices were developed for USAID review and used in planning final dissemination activities under the contract. There were almost 100 technical final products ranging from Manuals to Case Studies to Software to Working Documents to Pilot Site Videos, over 200 final grants products. This matrices are presented in Appendices 6.

Zdrav*Reform*/World Bank Collaboration: Resources for Sustainable Reform

In October, 1995 Zdrav*Reform* signed Letters of Agreement with the Territorial Funds of Tver and Kaluga Oblasts at the request of USAID Moscow to collaborate in the design and implementation of a series of pilot demonstration projects (working models). In Tver, Zdrav*Reform* established pilot demonstrations at five sites to test the following reforms:

- Incentive-based payment systems based upon capitation and prospective case-mix systems;
- Improved, standardized MIS with cost accounting, financial modeling, and financial management; and
- Continuous Quality Development (CQD) methods and approaches

In Kaluga, Zdrav*Reform* established the following pilot demonstrations at six hospitals and polyclinics, as well as the Health Committees and Territorial Fund in the oblast:

- Integration of financial flows, currently controlled by Health Committees and the Territorial Fund,
- Incentive-based payment systems based upon capitation, primary provider (partial) fundholding, and global hospital budgeting,
- Improved, standardized MIS with cost accounting, financial modeling, and financial management,
- Continuous Quality Development (CQD) methods and approaches

Zdrav*Reform* has provided TA, training, and software to design, implement, and evaluate these working models over the past year. The World Bank is planning to provide over $85 million to support the full implementation of these and other Bank sponsored pilots.

Grants of $95,000 each were awarded to Tver and Kaluga oblasts during Q1 1996.

Training programs were conducted in Tver and Kaluga during Q2 1996, addressing such topics as: Continuous Quality Development (Infection Control in Hospitals), and Global Budgeting (see Training section). These initiatives are designed to help prepare the oblast leaders for implementation of the pilot projects, and ultimately to better use the resources of The World Bank loans.

In June 1996, The World Bank team joined with Zdrav*Reform* (ZRP) to observe progress of ZRP's collaboration in Tver and Kaluga oblasts over the last 9 months. It was a busy week, with meetings starting Sunday morning, with discussions in both Tver and Kaluga going past midnight on some days. Three briefing binders were provided as background for Bank staff. Each pilot site, 5 in Tver and 6 in Kaluga, presented accomplishments and then were questioned on a range of structural and process changes underway.

On balance, the Bank was pleased and openly expressed confidence that substantive progress was evident in three areas: provider payment reform, quality improvement, and new approaches to management and information systems.

As might be expected, the "news" was better with some pilot sites:

- in Tver, good progress is evident at 3 of 5 pilot sites.
- in Kaluga, 5 of 6 pilot sites show excellent progress. Malayaroslavets rayon in Kaluga is the clear leader in the two oblasts. The rayon is developing a "rayon-at-risk" model, pooling its multiple sources of funds and implementing using new provider payment approaches: GP fundholding and hospital global budget. Utilization management systems and contracts have been developed, new quality improvement indicators are being perfected. Another Kaluga site, Polyclinic #1, has fully implemented a fundholding scheme that pools money for outpatient care, paraclinical services. emergency care, pharmaceuticals, and 30% of in-patient services (discretionary services).

Nevertheless, work remains in both these oblasts. In Tver, the information systems work is still only in the early stages, and some "foot-dragging" by the local leadership is apparent. Tver still must address the issue of pooling of funds as well. Financing of care is still fragmented, and the Bank was left with concerns about cost shifting under the new reform models.

II TECHNICAL RESULTS BY FUNCTIONAL AREAS

Output 1: Policy Support

The Zdrav*Reform* Program has contributed in a variety of positive ways to the reform of the Russian health sector. Substantial and sustainable contributions have been made to Russian health sector reforms in the following key strategies:

1. Encouraged meaningful policy debate by assisting in the design of selected policy forums and by granting interviews to mass media regarding priority reform topics:

    - Assisted USAID Moscow design and conduct a National Health Policy Roundtable during May 1995 in Moscow. This forum enabled senior health policy experts from Chile, the U.S. and the U.K. to meet with elected and staff leaders of the Duma's health sector committee to discuss 14 pending bills for health performance improvement. Relationships established during this experience helped nurture positive, though quiet lines of influence to important health policy makers at both the Federal and oblast levels throughout the remainder of 1995 and 1996.

    - Assisted the Moscow Health Insurance Association to design and conduct a major national conference in Moscow on the importance of expanded roles for primary care and general practitioners in Russian health sector reforms. Extensive mass media coverage of this event extended its impact throughout Russia.

    - Assisted the Federal Mandatory Health Insurance Fund (the Federal Fund) to design and conduct an international conference on the important role health insurance can play to catalyze and sustain health sector reform. Over 100 Federal and oblast health sector leaders participated in this Moscow conference in September 1995. Representatives from Israel, Holland, the U.K. and the U.S. contributed to these discussions. A comprehensive proceedings report was prepared and distributed throughout Russia by the Federal Fund. Extensive TV, radio and newspaper reporting also helped bring important topics into the mainstream of public awareness.

    - Zdrav*Reform* staff granted over 30 interviews to local, oblast and national print and broadcast media regarding issues and options for meaningful health sector performance improvement. These efforts have planted and nurtured seeds for reform throughout Russia.

    - Articles by Zdrav*Reform* senior staff appeared in newspapers, journals, radio and television to further generate receptivity to health sector reform ideas and models. For example, Dr. Stan Tillinghast published an article on Continuous Quality Development as part of a series on XXI Century Medicine, a special insert in the Russian journal Problems in Social Hygiene and Health Care History.

2. Informed the policy debate by making available extensive reference materials, especially published articles and CD-ROMs of reference items:

    - Small grants were used to help support the development of publications capabilities of new health professional associations so that they could become more effective vehicles for policy refinement and development. Zdrav*Reform* grants for such communication and leadership development were directed to new physician and nursing associations, management schools in Moscow, St. Petersburg, Kemerovo and Khabarovsk.

    - Assisted in the publication of a redesigned health economics

supplement for an established, conservative health sector journal via a grant to the Semashko Institute. This new "journal" featured articles and reactions that fostered enhanced discussion of health policy reform issues and options. Zdrav*Reform*'s Russian and American staff contributed written articles to this publication. The journal was distributed six times to over 2000 leaders throughout at 89 territories of Russia.

- Produced and distribute 2000 CD-ROMs that contained over 7000 pages of best practices reference articles from Western health sectors in order to provide practical ideas and experiences to Russian reformers.

3. Helped to establish a positive legal and regulatory context in which reform ideas and the pilot working models have a greater chance to flourish by performing the following activities:

- Jack Langenbrunner, Kevin Woodard, Igor Sheiman, Tatiana Makarova, Anna Korotkova, and Stan Tillinghast worked with The World Bank and Zdrav*Reform* to evaluate oblast level policy reform strategies needed in Tver and Kaluga to contribute to efforts to secure approximately $85 million of loan proceeds from a new World Bank Loan program targeted at health sector reforms.

- Stan Tillinghast, our Medical Director and Quality Improvement Expert provided by Joint Commission International (JCI), provided support to USAID Moscow in (a) the development of preliminary plans for a "partnership-exchange" between the American Medical Association and the All Russian Physicians Association; and (b) patient care and quality of care dimensions of a long-range master strategy or "Conceptia" for the Ministry of Health of the Russian Federation.

- Igor Sheiman and Tatiana Makarova completed a comprehensive "Concept Paper" or "Conceptia" on strategic reform proposals for the Russian health sector, which was submitted to a special workgroup assembled by the HPI-Boston cooperative program being managed by Dr. Svetlana Kruchinina. The paper also was submitted and approved by the federal Ministry of Health as a working model for Russian health care reform.

- Tatiana Makarova, with Jack Langenbrunner and Henry Leavitt, developed a model "waiver" decree in Tver oblast that provides legal authority for pilot site restructuring activity over the next 5 years, both under the Zdrav*Reform* program and the World Bank Loan program. In June 1996, the decree was signed by Governor Vladimir Platov.

- Zdrav*Reform* published of a series of "Discussion Papers" and reference materials designed to catalyze and inform debate among Federal and Oblast health sector policy leaders regarding various issues and options for health sector reform laws and regulations.

- Meetings and communications were expanded between Zdrav*Reform* and other foreign donor programs (The British Know How Fund and the TACIS Program of the European Community) as a means of enhancing Russian grass-roots reform policies that encourage primary care and general practice office developments.

- Strategy development was supported for two Moscow based projects that have the potential to positively influence future policy reforms:
  * the development of a "Strategic Business Plan" for "The Moscow Women's Health Center", a new public-private venture being established by the Foundation for Women's and Children Health in a facility donated by the City of Moscow; and

- ∗ the development of a draft "Strategic Business Plan" for a new "School of Public Health" to be supported by The Moscow Medical Academy and The University of Minnesota.

- Jack Langenbrunner and Stan Tillinghast participated in the Gore-Chernomyrdin Health Policy Roundtable in Moscow that brought together leaders from the United States and the Russian Federation.

4. Enhanced the capabilities of future health sector leaders. The Zdrav*Reform* Program recognized the importance of not just impacting the health policy makers of today, but to also influence the health sector reformers of the 21st century. Health sector reform will be an ongoing challenge in Russia, as it is a continuously evolving situation in all countries of the world.

   - Substantial investments in human capital development were therefore designed and accomplished by the Zdrav*Reform* Program throughout 1994-1996. Over 2000 health sector leaders were exposed to new ideas about health sector performance improvements via such diverse educational vehicles as:

     - ∗ Study tours in the U.S. and U.K.;

     - ∗ Local and national seminars, conferences and workshops in Russia;

     - ∗ Small grants to leadership development and training programs; and

     - ∗ Small grants to support the strengthening of new professional associations that will help sustain the flame of health sector innovation and performance improvement.

Output 2: Quality of Care Output

The Quality Improvement area was active in nine polyclinic and five hospital sites. The models developed encompassed ambulatory care quality indicators in 9 sites. Twelve principal indicators of ambulatory care quality were defined in 1995 by an inter-oblast Coordinating Committee of senior Siberian physicians. These indicators began being implemented in all of the six oblasts designed for intensive working model development.

The indicators have been incorporated into the Clinical Patient Records software developed in Kemerovo, Barnaul, and Tomsk, thus permitting polyclinics to monitor progress. The indicators chosen focus on treatment of such conditions as: ischemic heart disease, hypertension, congestive heart failure, diabetes mellitus, asthma, chronic obstructive pulmonary disease, peptic ulcers, lung cancer, breast cancer, colorectal cancer, and tuberculosis.

Five hospitals have been designated as the sites to establish modern, in-patient "Continuous Quality Development" (CQD) projects. These CQD projects began implementation in 1996 by specially defined and trained teams of physicians and nurses. The projects are intended to improve the processes of care delivery so that infection rates for medical-surgical patients and complications for routine births decrease from the 1994 baseline.

As a result of several pilot initiatives, a number of tangible outputs were completed during the project:

- Manual on Establishing CQD Manual for Hospitals;
- Quality Indicators for Ambulatory Care;
- Brief case studies of the process of implementing CQD projects;
- Workshop Packet on Infection Control in Hospitals;
- CQD Workshop for lowering infection rates which was held in both Siberia and in Central Russia; and
- Series of Discussion Papers
    - New Tools for a New Task: Quality Assurance
    - Patient As Partner
    - Evidence Based Medicine
    - Infection Control in Hospitals
    - Hospital Clinical Pathways
    - Quality of Care in Health Reform Conceptia: Russians Choose Life.

The following activities were carried out under the quality improvement tasks and related tasks:

Task 123 -- Hospital Continuous Quality Improvement
Under this task, the Zdrav*Reform* Team, led by Stan Tillinghast, collaborated with Oblast leaders head physicians in the four Siberian GFAs to 1) develop and implement continuous quality development projects in cooperating hospitals, and 2) produce case studies and a reference guide of how CQD projects are developed and organized; how the clinical or administrative problems are analyzed; how improvements in process are designed; how those process improvements are evaluated; and how processes with demonstrated success can be implemented on a wider scale.

Dr. Tillinghast prepared a final report which describes the individual case studies of CQD projects. Short descriptions of the case studies are described below, listed by site.

Kemerovo: The Zdrav*Reform* Team collaborated with Oblast CQI leader, Galina Tsarik, and with oblast hospital chief physician and deputy for quality improvement. The oblast hospital is the site of CQI efforts. The hospital has 1350 beds, 28 specialty departments, 10 surgical departments with 440 beds.

CQI Leadership Report - Dr. Tsarik prepared a report for the Kemerovo CQI leadership team. Her report outlines the evolution of the approach used to date in the Kemerovo oblast to assess quality of care. Medical-economic standards (MES) have formed the central role in assessment of quality for a number of years.

Development of Patient Satisfaction Surveys - In order to put a stronger emphasis on patient involvement and patient satisfaction with care, the Kemerovo oblast was beginning the process of developing patient

satisfaction questionnaires and incorporating their results into measures of quality of care. Zdrav*Reform* supported this effort by providing funding for the CQI project.

Dr. Tsarik prepared a report on this activity which summarizes the aspects of care related to patient satisfaction as follows:

- accessibility of outpatient and in-patient care
- competence and professionalism of physicians and paramedical personnel
- state of logistics
- status of the sanitary-epidemiological regimen
- organization of meals
- provision of medications
- adherence to ethical and professional standards by medical personnel

The general approach used is a combination of general screening questionnaires, with detailed follow-up questionnaires for identified problem areas.

Cardiology Center, Consultation on Reducing LOS after MI - Dr. Tarasov's team at the Kemerovo Cardiology Center brought about a transformation of the treatment of myocardial infarction patients in their hospital. The Kemerovo Cardiology Center succeeded in developing modern protocols for post-MI care that cut the average length of stay (ALOS) in half. They also consciously set out to comfort, reassure and educate their patients.

This example was used to encourage other oblasts to replicate the work in Kemerovo in ZRP CQI projects. Dr. Tillinghast found that using successful Russian examples of modern medical practices to demonstrate clinical quality improvement helped to eliminate the psychological barrier for Russian physicians that makes work done in the US seem impossible to transfer to the Russian situation.

Dr. Tarasov's team was used as consultants to the other Siberian oblasts in an interoblast project to reduce ALOS after MI. In the case of Altai Krai, it was clear that the Kemerovo example encouraged the physicians there to think more boldly about reducing LOS by replicating protocols similar to those used in Kemerovo.

Altai Krai: The Altai Krai oblast participated extensively in the Zdrav*Reform* quality improvement activities in Siberia. The Zdrav*Reform* Team collaborated with oblast CQI leaders, Tatiana Drachova and Ia Igorova, and with the hospital QI leaders at the cardiology center and Novoaltaisk Hospital.

Quality Improvement Leadership The report of the Altai Krai CQI leadership team describes the system of quality assessment used by the Altai Krai for licensing and accreditation; this is the primary system for quality assurance used by the state-owned health care system. The QA system described is part of the overall assessment used for licensing and accreditation. This includes--in addition to the components described in the report which attempt to measure the quality of care provided--assessment of the health care facility itself; qualifications of staff; and adequacy of equipment, supplies, and medications.

Troitsk Central Rural Hospital, TQM of Medical Care of Acute Pneumonia in a Rural Hospital - The continuous quality improvement (CQI) work done by the team of participants at the Troitsk Central Rural Hospital represents an example of CQI techniques applied in a rural hospital setting for a clinical problem of importance to that community. The project was carried out in cooperation with Altai Krai quality improvement leaders Yegorova and Drachova, and with ZRP oblast coordinator Sergei Chernikov, who provided local supervision of the project for ZRP. The results of the CQI analysis were presented to the supervising team, including Stan Tillinghast, Zdrav*Reform*'s expert on Quality, at the Troitsk hospital, as well as in the accompanying written report. This project had the strongest possible support and the active participation of the region's health care administrators, as well as the medical staff of the hospital and region.

As a community-based needs assessment, attention was paid to issues of early diagnosis at the primary care levels, appropriate triage and referral to more advanced levels of care, and continuity of patient care. The entire

structure and potential flow of patient care from rural emergency care stations up to the central hospital was analyzed, based on a survey of medical records of patients who had admitting or discharge diagnoses of pneumonia, or who had pneumonia as a reported cause of death. Particular attention was paid to cases that involved complications or misdiagnosis.

Cardiology Center, Barnaul, Reducing Length of Stay After Myocardial Infarction - Despite the availability of many modern interventions, the average length of stay in the Cardiology Center for patients following myocardial infarction (MI) is 25 days, according to the medical record review of 100 cases of patients with MI. There is widespread recognition in the Center that the average length of stay (ALOS) is excessive; this CQI project was intended to analyze the factors associated with prolonged LOS and try to change physician practices to reduce ALOS. As of the time of the report, the analysis had been completed, and work was underway on the development of new practice algorithms to encourage reduced ALOS. According to Dr. Tillinghast, this project, which has now become an inter-oblast cooperative effort to reduce LOS after MI, will result in significant practice changes that will both save money and improve the health of cardiac patients.

Cardiology Center, Barnaul, In-patient Diagnosis and Treatment of Hypertension - This project's goal was to reduce average length of stay (ALOS) in the hospital for diagnosis and treatment of arterial hypertension. Work of the CQI team began with the abstracting and analysis of 100 medical records of patients treated in the Altai Krai Cardiology Department (AKKD) in 1995. The report by the CQI team provides details of this analysis.

Tomsk: The Zdrav*Reform* Team collaborated with oblast CQI leader, Sergei Mikhailovich Khlinin, and hospital and polyclinic QI leaders. CQI projects were implemented in both the oblast hospital and City Hospital No. 3. Tomsk also participated in development of a rational pharmacy management seminar and development of system and inter-oblast effort to reduce LOS after MI.

Development of Ambulatory Care Quality Indicators - The work of the Tomsk oblast in the area of continuous quality improvement has demonstrated a degree of understanding and application of new quality improvement concepts that has surpassed our expectations. Dr. Khlynin's report indicates the scope of activities in which he and his colleagues in Tomsk participated in their cooperation with ZRP. Dr. Khlynin was an active collaborator in the interregional project to develop quality of care indicators for restructured polyclinics.

Rational Pharmacy Management, Developing of Medicinal Formulary to Treat Ulcers - Physicians of the Tomsk Oblast participated wholeheartedly in the interregional ZRP project to institute rational pharmacy management in our participating oblasts. With the cooperation of Management Sciences for Health and their USAID-funded program Rational Pharmacy Management (RPM), Siberian physicians were sent to Moscow for training in RPM. The report of the Tomsk participants reflects their application of this concept to one specific specialty: treatment of gastrointestinal diseases. The content of this report reflects a profound understanding of the benefits of the RPM concept and its great value for the Russian health care system in a time of financial crisis.

***Novosibirsk*:** Dr. Tillinghast was asked to become a part of the oblast working committee on quality management, headed by Dr. Melnikov. Furthermore, the concepts introduced by Dr. Tillinghast in a presentation to the committee were subsequently incorporated into the official oblast health care policy. This represented, in the opinion of Dr. Tillinghast, a giant leap ahead for Novosibirsk: they were willing not just to have demonstration projects on quality improvement and finance reform, but to integrate these ideas into the planning and implementation of health care for the entire oblasts.

CQI Leadership Report - Dr. Melnikov received support from ZRP's CQI component to write a report from the oblast leadership perspective on their cooperation with ZRP. His report gives a candid view of the evolution of Novosibirsk Oblast's interest in and participation in the Zdrav*Reform* Program. As part of our cooperation with Novosibirsk Oblast, we developed

several projects which were included in the CQI component of ZRP, based on the active interest of the oblast health care leadership.
These projects were carried out with the enthusiastic support of the practicing physicians of the participating hospitals.

Reduction of Nosocomial Pneumonia - Dr. Domnikova's report on nosocomial pneumonia reflects an excellent beginning to an effort that is still in progress. This report includes an analysis of serial autopsy data on patients who died in the hospital. A high rate of autopsy findings of pneumonia is reported: of patients who died in medical units, 89 of 228 autopsies showed evidence of pneumonia.

Hepatitis as Nosocomial Infection - Dr. Bocharov examines the important issue of iatrogenic infection with hepatitis virus from diagnostic and therapeutic procedures. He investigated the incidence of hepatitis cases arising from blood transfusions and other procedures. Of particular note in Dr. Bocharov's report is that almost half of the cases of iatrogenic transmission are associated with dental treatment.

Decreasing the Length of Stay After Myocardial Infarction - Dr. Tereschenko, Chief of Medicine at the Novosibirsk Oblast Hospital, provides a superb analysis of the contrast between Russian and international practices in the treatment of myocardial infarction, with emphasis on the excessive average length of stay (ALOS) in Russia.
Following our recommendations, Dr. Tereschenko studied 100 cases of patients admitted for acute MI, from February to April 1996. According to Dr. Tillinghast, Dr. Tereschenko's report and recommendations represent a significant step toward reducing excessive LOS after MI.

Quality Control and Improvement at Novosibirsk Oblast Hospital: An Overview - Dr. Fomin, deputy chief of staff of the Novosibirsk Oblast Hospital, provides a description of the environment in which quality control and quality improvement efforts take place. The complexity of funding mechanisms (state budget and mandatory health insurance) and underfunding (particularly on the budget side) make provision of high quality care extremely difficult. The development of a mechanism for QI involving a quality council and training of physicians, administrators, and mid-level personnel is outlined. The report provides only a brief sketch of the extensive work now being undertaken at the Oblast Hospital.

In summarizing the value of the new QI and QA programs, the director of Novosibirsk Municipal Hospital No. 1 states in her final report that:

> "Before the end of 1996 we plan to have identified at least 10-12 problematic issues of various levels, and to implement continuous quality management and assurance programs to address these problems. Some specific results of this work can be seen today.... However, the main achievement at this stage is introduction of the policies contributing to education and training of a new generation of medical professionals able to adequately formulate a problem, to work it out in explicit detail, make a quantitative assessment, analyze and improve the quality - all of this done with conscientious, accurate and consistent compliance with the concept in order to solve both global and specific issues."

Task 124 -- Ambulatory Quality Indicators

The inter-oblast QI committee consisting of QI leaders from the four Siberian oblasts and Dr. Tillinghast met several times, reviewing the highest volume conditions treated by primary care physicians for which current treatment is sub-optimal, and for which lack of high-quality outpatient care is likely to lead to increased hospitalization or significant decrease in health status of the population.

A set of indicators was developed, based on concepts outlined by Dr. Tillinghast from Western medical literature, amplified by discussions within the committee. The indicators have been approved with slight modification due to Russian financial circumstances in Kemerovo. The Tomsk oblast agreed to use the same indicators for the polyclinics involved in restructuring under Zdrav*Reform*. A similar set has been approved in Altai, which will be used on an oblast-wide basis. A paper has been written and

translated into Russian, explaining the rationale behind the use of the indicator set.

A seminar was held in Kemerovo to introduce the AQI set to the polyclinic leaders; approximately 30 attended.

Task 128 and 129 -- QI work in Tver and Kaluga

A Russian physician (Anna Korotkova) was hired on a half-time consulting basis to be the primary contact for QI for Tver and Kaluga. She spent several days in each oblast working with QI leaders at pilot sites and at the Territorial Fund and Health Committee. Both Tver and Kaluga began to develop ambulatory and hospital indicators as part of their pilot site programs. Kaluga oblast has planned to visit Kemerovo and Barnaul polyclinic sites where new quality and utilization software is being tested (see section below on Information Systems for more information).

A workshop was given in Kaluga on CQD related to lowering infection rates in hospitals. The workshop was led by Ed O'Rourke, MD, of Boston Children's Hospital, Carol Williams of Joint Commission International (based in the United States and part of the Joint Commission on Hospitals and other Organizations), and Stan Tillinghast, M.D. of the Zdrav*Reform* Program. The workshop was attended by about 30 participants from Kaluga and Tver. The seminar used working groups to develop indicators; later, the technical assistance team followed-up the workshop with visits to individual facilities for intensive training application of principles on site.

Output 3: Financing and Resource Management Output

The Russia Zdrav*Reform* Program has placed a special emphasis on the development of seven (7) new financing models. There are two clusters of these models: one cluster deals with different ways for purchasers of care to contract with providers of care (hospitals, polyclinics and physicians); and the other cluster addresses new ways to plan and manage the scarce resources within hospitals and polyclinics. Appendix 6 provides a profile of these seven models. There are over 50 Russian health reform experts who were under contract with Zdrav*Reform* to design, implement and evaluate these models.

As these models are implemented, more cost effective health care is expected. The output measures (discussed in the Overview in Section C) indicate that the new economic incentives and better financial management tools of the financing models should (a) cause care activity and expenditures to shift from in-patient settings (hospitals) to less expensive ambulatory care settings (polyclinics); and (b) ensure that provider accountability for the cost and quality of care would be more explicitly defined in formal contracts, i.e. that more of the hospital and polyclinic expenditures would be derived from contracts than from the traditional budget allocations. These results are already becoming evident.

Baseline data on health sector expenditures for 1994 indicated that 75% of funds are used for hospital care. In the rayons in which Zdrav*Reform* is implementing new financing methods and tools, new general practices and new hospital payments are starting the slow process of reorienting expenditures into the ambulatory setting. The work that was accomplished in the 84 project sites demonstrate the diversity and depth of progress achieved to implement these models. Exhibit 2 indicates which models were implemented at each site. Over 26 million people will be served by these new models, and related grantee organizations.

Most of these sites also seek to integrate the work and contribution of quality improvement models and the information systems innovations with the new payment and financial management models. This integration maximizes the contributions of each functional area toward achieving the overall project's goal of better quality and more cost effective health care.

Highlights of achievements include the following:

<u>Task 107</u> -- New Methods of Payment to Outpatient Facilities in Kemerovo

The goal of this activity was to develop and implement new payment methods for polyclinics which would motivate them to transfer some medical services to the outpatient care level and to improve health care resource utilization as a whole.

This task consisted of two components. The first component focused on improving the methods of funding polyclinics and included the following activities:

- development of case-mix capitation rates based on enrollment estimates,
- design and testing of mechanisms to motivate polyclinics to cut in-patient costs,
- design of a polyclinic in-structure payment mechanism which uses a computerized management information system,
- determination of payment rates for preventive care and in-patient care surrogates (overnight surgery centers, day care, home care),

The second component of the task focused on the transition to funding dentistry on a quasi-fee-for-service (points scale) basis.

These activities are being implemented in Kemerovo polyclinics 12, 5 (overnight surgery center) and dentistry offices. If successfully implemented these activities are expected to produce the following by the end of 1997:

- cut in-patient costs by 20% of the total care delivery costs of the pilot polyclinics
- improve patient satisfaction with the outpatient care quality provided,

- develop competition between dentistry polyclinics and improve quality of services
- establish a working polyclinic payment model to be further used by other care providers of the Kemerovo Oblast
- develop a manual on approaches to transition to new polyclinic payment methods.

The following activities were completed between January and August of 1996.

- Contracts were signed with Polyclinics 5, 12 and all Kemerovo dentistry offices, with the following attached: medical and economic standards and lists of services paid for on a completed case basis (preventive, in-patient care surrogates: day care, overnight surgery center), rates for services, final performance outcomes review models, as well as provisions of the polyclinic in-structure payment procedure.
- The method of payment for completed case was implemented using the in-patient care surrogates.
- The model of payment for preventive services based on a fee-for-service method was introduced.
- Methods of planning care delivery to be provided by pilot polyclinics were developed and are about to be implemented.
- New methods of payment for dentistry services are being used.
- The financial analysis was carried out that showed inadequate funding to pay for the local MHI program. The capitation rate was set for the fundholding polyclinic model.
- Monitoring and performance review of pilot polyclinics is being carried out.
- Proposals are under development for using the prospective polyclinic payment methods throughout the Oblast.
- Meetings and workshops were held for polyclinic managers and economists (21 in total). Polyclinic managers provided a training course to physicians and other clinical staff.

The main obstacles to implementing advanced polyclinic payment methods are:

- acute provider under funding
- lack of financial planning (planning care delivery based on funds available from all sources)
- lack of coordination between funding agents

These obstacles can be partly removed through other activities in which ZRP has been engaged, including insurer-provider contracting, improved cost accounting, performance review, comprehensive planning, monitoring polyclinic departments, and performance-based physician compensation.

The following indicators illustrate provide a profile of one of the pilot sites, Polyclinic No. 5.

Polyclinic visits/physician/year:

1994	7 008
1995	7 175

Share of preventive care visits, % to visits total:

1994	36.7
1995	35.4
1996	34.6

Share of home visits, % to total visits:

1994	7.3
1995	7.6

Successful treatment index:

1994	0.88
1995	0.96
1st half of 1996	0.96

Admissions/1 000:

1994	199
1995	159
1st half of 1996	64

Completed day and home care cases:

1994	596
1995	601
1st half of 1996	303

Day care paid, rubles:

1994	83,206
1995	155,287
1st half of 1996	108,397

Activities implemented by Polyclinic No. 5 include the following:

- Payment rates were set for overnight surgery, as well as fee-for-service rates. A contract was signed with the Kemerovo Health Insurance Fund to apply new provider payment methods.
- The overnight surgery center (OSC) was established.
- Most outpatient services are paid for on a capitation basis while priority services on a fee-for-service basis.
- Payment is based on a completed case (day and home care, overnight surgery, immunizations, screenings, other preventive services).

Task 140 -- Restructuring Polyclinics in Kemerovo

The purpose of this task was to design and test a new primary care model based on a freestanding general practice (GP). The working group implemented independent or semi-independent GP models at several pilot polyclinics of Kemerovo Oblast. The workplan included two phases.

Phase 1, April-December 1995: Development of legislation for FGP.

- The appropriate literature was studied.
- The appropriate primary care experience of the European countries was analyzed (East Germany, Ireland, UK, Portugal). The study tours were carried out by the pilot polyclinic personnel (physicians, health managers).
- The facilities and equipment of care providers were evaluated and pilot territories were identified for testing the primary care reform mechanism (Anjero-Sudjensk, Belovo, Berezovsky, Kemerovo, Mezhdurechensk; as well as regions: Kemerovo, Yurga Promyshlennovsky).
- The number of physicians in Kemerovo Oblast was assessed, as well as the ratio of specialties and general physicians (catchment area physicians, pediatricians) both in the Oblast and pilot territories.
- The program of opening up GPs in pilot territories was devised by each health facility .
- The concept of restructuring polyclinics into freestanding GPs was developed, with the reform phases determined.

The following *draft laws and presentations* were prepared during Phase 1:

- General GP Establishment Guidelines.
- Standard charters of various GP legal status and ownership type.
- Standard contracts regulating relationships of GPs with other parties (local authorities, health insurance companies, care provider management, other GPs, etc.).
- GP licensing and accreditation provisions.
- Provisions for GP payment and physician compensation methods.
- GP under- and post-graduate education program.
- Provisions for general practitioner.
- Provisions for GP assistant.
- Enrollment guidelines.
- Medical and economic standards.
- The Oblast conference on primary care reform was held.

In 1995-96, the Kemerovo State Medical Academy and leading health facilities trained 14 GPs, with the training cycle ending in May 1996.

Phase 2 January 1996- September 1996

This phase was devoted to implementing the GP structure at the pilot health facilities, specifically:

- adjustment of the draft laws and regulations to individual GPs
- individual training of managers of GPs and leading polyclinics, including on-site training
- testing new GP funding mechanisms
- monitoring medical and economic performance of GPs
- quality of care assurance.

The Oblast polyclinics' performance was reviewed to compare the following indicators: polyclinic visits/resident/year, structure of outpatient care, share of primary care, number of admissions/enrollment, etc. Based on the draft legislation and regulations developed and initial GP performance experience gained, a manual entitled *Developing Freestanding GPs* was prepared for distribution all over Russia.

While the original plan was to establish nine GPs, ten were actually set up, with 2 more under development (Berezovsky, Kemerovo region). Additional group practices were established in Mezhdurechensk, Leninsk-Kuznetsk, and Yurga.

Of the GP offices opened, 3 are individual (one in the rural area) and 7 group practices. All GPs are funded using the capitation rate including some types of outside costs. This results in GPs turning into partial fundholders in their relationships with other care providers. The fundholder approach is used only for specialty consultations and diagnostics., though future plans call for expanding the fundholding practices.

Following are the differences between general practitioners and polyclinic catchment area physicians?

- Their relationships with polyclinic management are regulated by contract.
- The polyclinic opens a bank subaccount for GPs to accumulate all its funds depending on the payment method.
- GP will bear the brunt of risks.
- Compensation is based on GP medical and cost efficiency.

The Group GP of Kemerovo Polyclinic No. 5 is one example of the newly formed practice. It has been operational since January 1995 as a structural component of the polyclinic. It owns premises with a separate entrance. The polyclinic management has developed a GP Provisions and issued the respective Chief Doctor an ordinance. A contract has been signed between the GP and polyclinic management specifying the relationships between them including the referral procedure and payments by GP.

The GP has its own bank subaccount and is funded based on the capitation rate set for integrated polyclinic service contingent on the GP operating situation. The GP enrollment is 10,000 adults, with 1, 460/physician.

As provided in the contract, the GP pays the polyclinic for specialty consultations, medical treatment and diagnostics provided by the outside rates. The GP assumes part of the risk associated with the polyclinic payment.

The capitation rate does not comprise polyclinic administrative and logistics costs.

All GP physicians received post-graduate training at the Kemerovo Medical Academy.

GP Staff:

GP chief	1
Physicians	5
Nurses	5
Receptionist	1
Aide	1

GP office funding in the first 5 months of operation amounted to 361,538,712 rubles against expenditures of 346,674,682 rubles, yielded net profits of 148,640,030 rubles ($27,525). During this short period of

operation, the GPs appear to demonstrate evidence of sustainability, while the polyclinics needed additional budget allocations.

Task 143 -- Managed Care Model in Kemerovo

It is a major drawback of the Russian health-care system that it is not sufficiently integrated in terms of function, management and finance. Its serious structural distortions lead to low operating efficiency.

The central idea underlying this task is that the medical community and the insurance community must be rallied to tackle together a common task - efficient management of healthcare resources and quality. To accomplish this objective, a vertically integrated multi-level health care system was organized under the supervision of a health insurance company. This system is financed on a capitation basis, with money coming from consolidated fund sources.

The task used three pilot facilities to create integrated systems for financing and providing health care, to be known later on as *health insurance associations (HIA).* It emphasizes the development of new forms of contractual relations between health insurance companies and health facilities, and the use of capitation-based financing of an integrated health care network, the development of economic interests that would be common to all the health-care system levels, planning the volumes of health care, management of the quality of health care and the use of resources. Some of the approaches in use have been borrowed from the practice of US health-maintenance organizations (HMO).

Three health insurance associations were used as pilot facilities: a municipal health association, a village territorial health association, and a city polyclinic.

This working model is expected to improve care delivery structure and the efficiency of resource utilization through the use of resource-saving technologies, new payment methods and the management of care delivery process. Priority should be given to the development of primary health care and a variety of technologies substituting for in-patient care. These efforts are expected to lower the level of admissions and reduce the share of expenditures on in-patient care.

The following major products were part of this task:

- The team developed a concept of an integrated health insurance system that fits the Russian scene. Forms of civil law relations were selected for use by a medical insurance association that are not in conflict with Russian law. The concepts were developed based on materials furnished by US experts, consultations with experts in managed health care about practical matters, and the experience of a number of Russian experts gained through study tour of health maintenance organizations in the U.S. American literature devoted to practical work of a health maintenance organization was translated into Russian.

- The team defined the organizational and legal aspects of the work of a health insurance association and the civil law aspects of internal and external relations of an association that are not in conflict with Russian law.

- Three health insurance associations were established, each with its own organization and technology: **Tisulskaya Health Insurance Association** is located in a village territorial medical association that is remote from cities and that has its own extensive medical assets; **Kedrovskaya Health Insurance Association** is located in a municipal health association that offers a full scale of medical services provided for by a mandatory health insurance territorial program; and **Stroitel Health Insurance Association** uses the facilities of an enterprise-based polyclinic that does not have a hospital base.

- The insurance component of each HIA was handled by the *Kuzbass Oblast Health Insurance Department* Kuzbass and its branches**.**

The following steps were implemented at every health insurance association:

- Health insurance association structures were established that bring together medical workers and insurers; a contractual system of internal and external relations was created.
- The health insurance association was switched over to capitation financing.
- Various sources of funds were consolidated, and resources are managed by a single structure.
- A quality-management system was established that also manages resources.
- The managerial personnel were trained in the use of resource-saving organizational and medical technologies.
- Methods were developed and are currently in use for planning and management of admissions and costly medical technologies.
- Ceilings have been put on the use of health care by members of a health insurance association at external health facilities (oblast health facilities and those outside the region).
- Some elements of partial fundholding were introduced and full fundholding was introduced at the Stroitel Health Insurance Association; these elements are managed by the polyclinic, a primary health care link. The share of hospital care and external services that are paid directly from these funds has been determined.

It is not possible to complete a serious assessment of the outcomes of the project yet because the health insurance association has not been in existence long enough. Nevertheless, there are signs indicating emerging positive trends, in particular at the Tisulskaya Health Insurance Association.

Tisulskaya Health Insurance Association

Reduction of bed capacity due to changes in the structure of health care delivery.

Year	Reduction of capacity
1995	57
1st half 1996	40
Total	97 eliminated

After a year and a half of operation, the health insurance association eliminated 97 beds. The first beds to be eliminated were those that were occupied fewer than 250 days per year. Thirty-eight beds at in-patient units of the area hospitals became health/social care beds. Two in-patient therapy units of the area hospital became nursing units.

Development of Outpatient Technologies Substituting for In-patient Care

A fifteen-bed day care unit opened that uses outpatient/polyclinic facilities; the unit treated:

Period	Number of completed cases
1st half-year of 1995	228
1st half-year of 1996	312

There is a pronounced rise in the number of completed outpatient cases while the number of admissions to in-patient facilities is dropping. Endoscopic treatment of duodenal ulcers has been mastered. This technique made it possible to treat about 60% of the cases at the polyclinic.

Disease Prevention.

98% of the catchment area population undergo regular medical examinations organized through the implementation of a new computerized information system.

Changes in Internal Economics.

The economics of an integrated system is based on the principle of consolidated budget. Funds are consolidated at the level of a territorial

health facility pursuant to the G*uidelines on Consolidated Budget.* A differentiated capitation rate is calculated at a health insurance association; the rate is equal to 18,290 rubles per month, as compared with an average oblast capitation rate of 13,000 rubles per an insured person within the mandatory health insurance system.

These models have introduced partial fundholding by primary care doctors. A primary care doctor receives funding in proportion to the number of enlisted population based on the calculated consolidated capitation rate per insured person. A doctor at a primary health care facility supervises referrals to oblast health facilities, referrals to specialists, and patient use of paraclinical services. In-patient care is financed by the health insurance agency on the basis of completed cases and in accordance with health economic standards.

The pilot sites also employ an incentive system for primary doctors and managers of hospital wards to encourage them to reduce admissions. Payment for priority activities, in particular disease-prevention services is on a quasi-fee-for-service basis. The fact that 98% of the population has received a preventative medical examination is proof that this payment method is efficient.

The HIAs all employ a system of admissions control. A primary doctor is provided with an admissions plan/order. This plan/order is based on a thorough analysis of the activities of individual doctors; on examples of their inefficient work; and on planned efforts to strengthen the outpatient facilities. On a monthly basis a commission comprised of polyclinic director, chief doctor of the in-patient unit and a representative of the health insurance agency adjusts the admissions plan/order.

Below are figures that characterize some of the indices of Tisulskaya Health Insurance Association and that are a measure of the shifts taking place.

Indices	1st half-year of 1995	1st half-year of 1996
Number of completed cases	2,315	1,897
Average length of stay	11.4	11.0
Expenses on 1 bed-day	67,038	113,134
Cost of 1 completed case	781,709	1,200,000
Admissions	68 per 1000	56 per 1000
Percentage of primary care doctors in relation to total of doctors	10.26 %	10.26 %
Frequency of referrals of patients by catchment area doctors to specialists	43.9 %	30.37 %
Number of population calls to ambulance stations	4,312 per 1000 population	4,548 per 1000 population
Scope of disease-prevention efforts	96 %	98 %
Number of hospital beds at pilot area per 10,000	96 %	70,3 %

These figures clearly point to an increase of cost efficiency:

- a reduction of bed capacity at the Central Area Hospital
- a lower admissions level
- a lower referral frequency at the outpatient stage
- chronologies substituting for in-patient care are introduced vigorously.

<u>Task 141</u> -- Restructuring Polyclinics into GPs in Tomsk

The main goal of this task was to provide support to the programs and endeavors of the Tomsk Oblast to assist in improving cost efficiency of care delivery, quality of services and enhance provider choice while retaining free access to care providers.

A workshop of health leaders and experts was held in December 1993 in Tomsk, which was attended by representatives of Tomsk, Novosibirsk, Altai Krai, and Kemerovo, which focused on the current problems of health care, reiterated the sector readiness to carry out its reform, convinced leaders of the importance of reform, and defined the main reform goal. An important outcome of the workshop held was defining the following unsolved problems:

- lack of linkage between care delivery and funds available;

- lack of potential funding estimate from the budget, employer premiums and direct institutional investments;
- lack of consideration for non-governmental funding sources, the fledging NGO health care and paid services segment; and
- lack of consideration for cost cutting clinical pathways, modern health structure and management.

Their work has produced the following assumptions regarding, first of all, conclusions on health policy:

- since costs grow fast and the inflation rate may as well, Oblasts may have to resort to various cost cutting measures
- there should not be several provider payment methods at Phase 1 of the reform
- a centralized model, a certain form of global budget will be beneficial
- limits imposed on health-related costs will lead to lower costs to an appropriate level

The general plan of activities to approach the ZdravReform project was structured:

1. Signing the letter of intent between the local government and ZRP.

2. Ordinance by the Chairman of the Tomsk Oblast Government "On Implementation of the Letter of Intent Signed with ZRP." A health care reform program was developed under the ZRP project, complying with the Tomsk Oblast health care policy, Letter of Intent and Grant Agreement signed between Oblast government and USAID, with the following guidelines approved:
    - improving quality of care
    - restructuring polyclinics into freestanding general practices
    - efficient funding and resource management
    - improving medical information systems

3. Establishment of the Coordinating Council.

4. Staffing the project.

5. Defining the main work, funding, and resource management under their two projects:
    - Restructuring Polyclinics into GPs
    - Developing New Hospital Payment

The project deliverables developed in Project Phase 1 include the following documents:

- "Concept of Restructuring Polyclinics into Freestanding General Practices";
- "GP Physician Intensive Training Course," containing the curriculum for post-graduate training and certification of catchment area physicians;
- "Legal Status and Structure of FGPs";
- Contract Forms considering GP cooperation options, Charter and Founding Agreement;
- "General Guidelines to Establishment and Equipment Supply to GP Offices Located at Pilot Sites and GP Staff Duties";
- Collection, Processing, Evaluation, Exchange and Storage of Data on GP Activities, Patient Records, GP Quality Indicators and their Impact on Care Delivery, Licensing and Certification Provisions;
- "Guidelines to GP Staff Compensation"; and
- "GP Regulations."

The primary objective of the second phase of work on New Provider Payment Methods was to prepare the transition of two pilot sites to the new method of paying for medical services. The following tasks were performed:

1. The existing procedure of costing in-patient services was evaluated and rates set for hospital services. Improvement methods were recommended.
2. Advantages and disadvantages of Tomsk Oblast hospital payment procedure were identified.
3. The new hospital payment method was implemented, Global Budget, using two GB versions at two different pilot sites.

The following manuals were prepared:

1. Detailed description of new approaches and methods of costing in-patient services;
2. Recommended strategy of implementing alternative methods;
3. Guidelines to rate setting for hospital services based on total funding under the TMHI program;
4. Statements related to new payment method testing and its outcomes; and
5. Description of methods and principles of hospital contracting.

The integrated cost accounting model was implemented at two pilot sites.

The global budget method was used by Oblast Clinical Hospital based on completed case.

The following deliverables were developed under Phase 2:

- "Developing Integrated Cost Accounting and Analysis System Modeled on Methods";
- "Development, Adjustment and Unification of the Medical Services Code";
- "Provisions on Funding Pilot Sites Based on Completed Case (practical guidelines)";
- "Developing Contract Forms for Funding Based on Completed Case (practical Guidelines)"
- Studies on evaluation of the performance of the Oblast Clinical Hospital, code of and rates on medical services aiming to develop a new provider payment method (three packages);
- Revised medical economic standards;
- Provider payment methods, changing care delivery structure and its impact on provider performance indicators and health care; and
- Enhanced evaluation of the existing payment methods seen by the MHI fund, hospitals and Health Committee.

The overall results of this task were as follows:

1. The comprehensive Tomsk Oblast health care reform program is being implemented under the ZdravReform Program.
2. Pilot polyclinic departments were restructured into general practices, with the respective practical guidelines and manuals developed.
3. The new hospital payment method was implemented based on completed clinical case.
4. The quality assurance procedure (CQI method) was proposed to be used during the implementation of the new provider payment methods.
5. The medical information system was established to serve GPs and pilot hospitals using the PCs provided by the Zdrav*Reform* Program.
6. All clinical staff involved in the project on implementation of the new resource utilization method and quality assurance underwent training.
7. Implementation and testing of the new clinical pathways were monitored using intermediate and final performance indicators, with the positive experience obtained.
8. The appropriate legislation and regulations were developed for dissemination of the new care provision technologies in the Oblast providers.
9. The Health Committee, TMHIF and the insurer discussed the prospective health care reform plan considering the ZRP outcomes.

<u>Task 161</u> -- New Methods of Payment to Hospitals - Tomsk

Two (2) pilot hospitals started the process of implementation of new payment methods in Q1 of 1996 and fully implemented these in Q2 of 1996. The oblast hospital has implemented a hospital global budget, using case-mix adjusters – 390 groups using a modified classification scheme developed and presented by Sasha Telyukov. City Hospital #3 in Tomsk have started a new case-mix payment implementation. The hospital has developed 400 categories, based on diagnosis, procedures, and lengths of stay. The new system was started on June 3, 1996. The project also was part of the fast track grant program (#30.005). The two hospitals have started a cooperative Utilization Management Program.

The primary objective of this task was to prepare for the transition of two pilot sites to the new method of paying for medical services. The following were the key steps in this process.

- The existing procedure of costing in-patient services was evaluated and rates set for hospital services. Improvement methods were recommended.
- Advantages and disadvantages of Tomsk Oblast hospital payment procedure were identified.
- The new hospital payment method was implemented, Global Budget, using two GB versions at two different pilot sites (Oblast Children's and Hospital 1).

In addition, the team prepared the following manuals:

- detailed description of new methods of costing in-patient services.
- recommended strategy for implementing alternative methods.
- guidelines for rate setting for hospital services based on total funding under the TMHI program.
- statements related to new payment method testing and its outcomes.
- description of methods and principles of hospital contracting.

The integrated cost accounting model was implemented at two pilot sites and incorporated the following:

- electronic cost accounting.
- operating cost tracking
- cost analysis ("what-if" scheme of estimating).
- determination of cost efficiency of labor, facilities equipment and financial resources (separately and together).
- Excel tables allow monitoring payments and data input procedure.
- fast evaluation of final outcomes when certain costs change (expense items)
- fast receipt of data on redistributed resources between various services (departments) when accounting indicators change, e.g. premises used, staff, etc.)

The integrated cost accounting system is supported by Excel 5.0 for Windows, as well as advanced data retrieval software, graph and chart design allowing to get data in a form convenient for management analysis and decision-making.

The global budget method used by Oblast Clinical Hospital was based on a completed case approach. This method features the following:

- coordinated appropriate classification implementation
- rate setting based on neutralized budgets.

The global budged was used in Hospital No. 3 in two ways:

- case-mix capitation rate based on hospital DRGs; this part of the capitation rate (27% of the enrollment) is derived through the structure of completed cases
- admissions: completed case based on the cost of one bed-day

These methods were authorized for implementation starting June 3, 1996. These methods were tested for two months and problems began to emerge. The transition to GB was carried out without a sufficiently deep evaluation of the community needs for various types and costs of services. One particular problem was the rate approval procedure intended to reimburse potential losses and actual costs.

The following deliverables were developed under the activity "New Provider Payment Methods":

- Developing Integrated Cost Accounting and Analysis System Modeled on Methods Proposed by Sasha Telyukov of Abt Associates Inc. Pilot Site: Tomsk Hospital 3.
- Development, Adjustment and Unification of the Medical Services Code. Adjustment of Hospital 3 Code.
- Provisions on Funding Pilot Sites Based on Completed Case (practical guidelines).
- Developing Contract Forms for Funding Based on Completed Case (practical Guidelines).
- Studies on evaluation of the performance of the Oblast Clinical Hospital, code of and rates on medical services aiming to develop a new provider payment method (three packages).
- Revised medical economic standards.
- Provider payment methods, changing care delivery structure and its impact on provider performance indicators and health care. Enhanced evaluation of the existing payment methods seen by the MHI fund, hospitals and Health Committee.

<u>Task 142</u> -- Restructuring Polyclinics into GPs in Altai Krai

Four polyclinics in the city of Barnaul and two central hospital/polyclinic facilities in the city of Novoaltaisk and in Troitsk District are being used to test the model of delivery of primary and specialized (gynecological, surgical, neurological, ophthalmologic, etc.) care based on freestanding or autonomous general practices. The first 10 high-skilled physicians completed training in family medicine and received certificates and licenses. With some funding from the Zdrav*Reform* Program, the Altai Krai Health Committee acquired equipment for general practitioners.

These general practices titled *Outpatient Facility of General Practitioners/Family Doctors* are located in the following health facilities: polyclinic No. 9; hospital/polyclinic in the village of Yuzhny; polyclinic No. 4 in the city of Barnaul; hospital/polyclinic in the city of Novoaltaisk; and a village outpatient facility in Troitsk District. The opening of the first practice took place on September 25, 1995. Two of the general practices are operating as sustainable legal entities, and the remaining ones, as autonomous polyclinic units.

As of September 1996, the oblast was preparing a bill "On Health Protection of Population of Altai Krai" that would lay down a legal basis for the creation of general practices. Reluctant to wait until this bill becomes law, the Head of Altai Krai Administration issued a regulation "On a Gradual Transition to the Organization of Primary Health Care in Altai Krai as General Practice (Family Doctor)". Additionally, a Memorandum was signed to provide for collaboration in this field between the Health Committees of the Krai Administration and the Territorial Mandatory Health Insurance Fund. These measures have given a boost to the practical implementation of this urgently needed health-care initiative.

Before implementation of work under Task 142 began, a fast-track grant assisted the oblast with the following activities that laid the foundation for the formation of general practices:

- Development of a concept for the restructuring of the polyclinics, including mechanisms to provide for financial, administrative and operational autonomy of general practitioners/family doctors;
- Preparation of legal and constituent documents that are required to carry out the restructuring;
- Definition of new functions and responsibilities of the health-care system officers in connection with the opening of family practices at polyclinics;
- Development of model agreements that regulate relations between payers and workers of family practices and between family practices and polyclinics; and
- Definition of a procedure for licensing and accreditation of family practice workers.

Equipment was purchased to equip three practices: one in Barnaul, one in Novoaltaisk and one in Troitsk District. The equipment included:

1) general practitioner equipment sets from Welsh Ellin, USA; stationary and portable opthalmoscopes; transformers; lighting fixtures, gynecological speculums with autonomous and floor lighting, episcopes;

2) Mini-electrocardiographs with computer software;

3) Sets of medical furniture of a general practitioner. The equipment was distributed among 5 facilities in accordance with the plan.

The administrations of the city and of the Industrial District and the Health Committee contributed more than 40,000,000 rubles from the state budget as the city authorities' contribution to the rebuilding of Outpatient Facility No. 9 (doctor O.A. Gnusova). More than 100 mn. rubles has been spent from the state budget on the rebuilding of practices in the village of Yuzhnoye and Polyclinic No. 4. A shortage of money in 1995 and 1996 prevented the Krai Health Committee from providing the same volume of assistance for the rebuilding of the premises for the remaining general practices, which is the main reason behind a delay in the opening of the practices.

The general practices have encountered more difficulties then they expected. The largest obstacle to the implementation of the project is the Law on Local Self-Government that is valid throughout the Russian Federation. This law basically defines its own budget and lays down a legal climate in an administrative entity, not only a krai but also a district and a city.

The fragmentary formation of a local budget virtually precludes a switch over to a single capitation rate to be used as a financing instrument or a system of settlements between a general practice and specialists. Prices of specialists' services that were calculated for the krai as a whole proved unusable in some of the districts of Barnaul and Novoaltaisk.

For example, Barnaul forms six parallel budgets because health care continues to be delivered to the population at enterprise-based hospitals that are off-limits to general public, at hospitals of the Railways Ministry, those of the Interior Ministry, Heavy Machinery, etc. Under these conditions it proved impossible to switch to a system of capitation funding of general practice with fundholding elements as had been intended. At a later stage it is necessary to take efforts to form a single capitation funding rate and unify prices for specialist services.

In addition, 1995 and 1996 were very stressful for the krai in terms of health care financing and organization: payment of wages was delayed 3-4 months; the medical community was continually threatening industrial action; and there was a top-level reshuffle at the Health Committees in the krai and in Barnaul. Today arrears of wages are 3.9 bn. rubles in the krai; and total arrears, including the money that should have been appropriated for capital repairs, equal 160 bn. rubles.

Last year an off-set system became widespread in the krai to pay for electricity, water supply and heating. It is also common to receive wages and salaries in kind (sugar, meat products, etc.). Repairs, construction, and medicine are often paid for with promissory notes. Federal budget debts are often repaid in medicine to the krai, and even these deliveries are undependable. There is no precise arrangement covering relations between state budget money and money of the mandatory health insurance territorial fund. For these reasons the krai has failed to introduce a capitation-based compensation structure at a general practice.
The group general practice at polyclinic No. 9 in Barnaul managed by O.A. Gnusova is one illustration of the progress of new GP s in Altai Krai. It was set up by special order of the head of administration of Industrial District of Barnaul on September 25, 1995. Personnel include: 2 General Practitioners, one feldsher/obstetrician, 2 nurses. It services a population of 6000. In addition to a general practitioner, specialists offer all kinds of specialized outpatient care.

A visit to the group general practice cost 10,998 rubles in June 1996 while at the base polyclinic it cost 13,957 or 1.3 times more. The cost of a visit to the general practice is lower due to the fact that the GP equipment was financed with grant money and the base polyclinic pays the drug benefits.

A GP general practitioner received 1.4 more patients during the six months than his colleague at an average polyclinic catchment area (2604 and 1800 respectively). In addition, the general practitioners received the following patients during the six months: ENT, 320 (53 per month); neurology, 650 (108 patients per month); ophthalmology, 120 (20 per month); gynecology, 400 (66 per month); urology, 200 and proctology, 200 (33 per month); surgery, 320 (53 per month); traumatology, 120 (20 per month); teenagers, 200 (33 per month).

Functional methods were used to examine 300 patients (50 per month). Analysis of the work of ordinary catchment area physicians makes it clear that the number of referrals ordinary physicians make is equal to the number of patients a general practitioners treats on his own. It should be emphasized that General Practitioner O.A. Gnusova received 5,414 patients during the first six months, which is more than an average annual general physician's load.

	General Practitioner	Catchment area physician
Referrals/total visits, %	7.3	20.6
Completed cases, %	96	82
Admissions/1000	17.1	19.6

When these trends were discovered, the base polyclinic managers eliminated a gynecologist and assigned all enlisted patients to the group general practice.

Thus, the model of an autonomous group practice using the facilities of a municipal health facility is extremely profitable for the base polyclinic and population if the general practice is outfitted with medical equipment. However, since the group practice is not using a capitation-based general practitioner's compensation system, it does not stimulate general practitioners to further improve their work.

Task 142 -- Multilevel System of In-patient Care in Altai Krai

A model for separating acute and sub-acute in-patient care has been developed. A procedure for ensuring continuity for early hospital discharges; and payment rates for completed cases have been designed.

Full scale implementation has not occurred due to deteriorating funding within the economy of the Oblast. Hospital leaders worked with Igor Sheiman of the ZRP to complete a manual on "How to Develop Multilevel System of In-patient Care."

Task 142 -- Developing and Costing the Package of Medical Benefits in Altai Krai

A new methodology of developing and costing the package of medical benefits has been developed and tested. A number of options have been costed on the basis of financial modeling approach. A manual on pricing of benefits was developed by a group of Altai, Kemerovo and Moscow specialists.

Task 149 -- New Payment Models in Tver Oblast

The training program for key building blocks of payment reforms is complete (8 seminars). In April, the final workshop on hospital global budgeting was held in Kaluga oblast. Plans are developed for the pilot sites. Programs of utilization management and standard provider payment contracts were developed in Q1 1996.

In Q2 of 1996, in-patient and outpatient costs were tracked; both direct and indirect. Patient flows were analyzed, especially relevant to the rayon-level pilot sites which historically have referred many patients to oblast-level facilities.

Utilization management data were collected and analyzed, with a focus on identifying

- Inappropriate admissions;
- Pre-admission duplication;
- Opportunity for shortening lengths-of-stay; and,

- Alternatives to hospital care, such as care on an outpatient basis or in day care centers for "social cases."

These data will be used to develop more precise payment rates.

Development of payment rates was completed, using a capitation (rayon-at-risk) model for rayons and a global budget for urban hospital sites, with age/sex adjustments (hospitals in rayon sites will be paid on a completed case basis using case-mix or some version of clinical statistical groups). Some sites have developed a physician incentive bonus strategy using positive performance indicators.

A World Bank team joined with Zdrav*Reform* (ZRP) in June to observe progress of ZRP's collaboration in Tver oblasts over the last 9 months. Each pilot site presented accomplishments and then were questioned on a range of structural and process changes underway.

On balance, the Bank was pleased that substantive progress was evident in provider payment reform. As might be expected, the "news" was better with some pilot sites. Good progress is evident at 3 of 5 pilot sites.

Tver still must address the issue of pooling of funds. Financing of care is fragmented, and the Bank representatives had concerns about cost shifting under the new reform models.

Task 147 -- New Payment Models in Kaluga Oblast

The training program has been completed (8 seminars). The final seminar was held at the end of April on hospital global budgeting. About 25 leaders and pilot site technicians attended. The workshop focused on working out the relationship of payer and hospital providers being paid on a global budget basis. The workshop focused secondarily on developing outpatient fundholders. The British reforms over the last few years, particularly their use of new autonomous trusts and GP fundholders were used as one example for the new payment reforms for Kaluga oblast. The chief faculty leader was Mr. Bob Dredge, Chief Financial Officer of the Wolverhampton Hospital Trust of the National Health Service in the United Kingdom. The workshop was collaboratively funded primarily by World Bank and the Zdrav*Reform* program. It was part of a larger package of manuals, materials, and technical assistance over two visits in April and July of 1996.

Plans were finalized for the pilot sites, and implementation activity began. In Q2 of 1996, in-patient and outpatient costs were tracked; both direct and indirect. Patient flows were analyzed, especially relevant to the rayon-level pilot sites which historically have referred many patients to oblast-level facilities.

As with Tver, utilization management data were collected and analyzed, with a focus on identifying:

- inappropriate admissions;
- Pre-admission duplication;
- Opportunity for shortening lengths-of-stay; and,
- Alternatives to hospital care, such as care on an outpatient basis or in day care centers for "social cases."

These data will be used to develop more precise payment rates.

Development of payment rates was completed, using a capitation (rayon-at-risk) model for rayons and a global budget for urban hospital sites, with age/sex adjustments. Polyclinic sites will implement a partial fundholding model, with funds for all primary care, pharmaceuticals, emergency (ambulance) care, specialty referrals, paraclinical services, and some discretionary portion of in-patient care. Some sites have developed a physician incentive bonus strategy using positive performance indicators.

Implementation for one site, Polyclinic #1, started in May 1996. Expected implementation for remaining sites was expected to occur by the end of 1996.

As in Tver, the World Bank team joined with ZRP technical staff to review progress over the last 9 months. Pilot sites presented and then were questioned on a range of structural and process changes underway.

On balance, the Bank openly expressed confidence that substantive progress was evident. In Kaluga oblast, 5 of 6 pilot sites showed excellent progress. Malayaroslavets rayon in Kaluga is the clear leader in the two oblasts. The

rayon is developing a “rayon-at-risk” model, pooling it’s multiple sources of funds and implementing using new provider payment approaches, GP fundholding and hospital global budget. Utilization management systems and contracts have been developed, new quality improvement indicators are being perfected.

Thus, new financial models are being developed, tested and documented. There is clear evidence of enthusiasm for restructuring payment schemes, both by counterparts and other donors. The project, however, continues to face some economic and political problems which make the implementation of working models a hard job for the local groups. First, funding of health providers is worsening throughout Russia and getting less stable. This fragile situation will jeopardize implementation, for example, of the fundholding scheme. Second, a political instability before the presidential elections has raised hard issues about the future of health insurance in oblasts.

EXHIBIT 2: FINANCING MODELS BY SITE

(SEE APPENDIX 6 FOR DESCRIPTIONS OF THESE MODELS)

1. OUTPATIENT PAYMENT MODELS:

KEMEROVO OBLAST.
- POLYCLINIC N5
- POLYCLINIC N12
- POLYCLINIC N3
- DENTAL POLYCLINICS IN KEMEROVO CITY
- MEZHDURECHENSK CITY POLYCLINIC
- BELOV CITY POLYCLINIC
- BEREZOVSKY CITY POLYCLINIC
- BEREZOVSKY FELDSHER STATION
- ANZHERO-SUDZHENSK CITY POLYCLINIC
- KRASNIN DISTRICT HOSPITAL
- FELDSHER STATION IN YURGA RAYON
- "GIPPOKRAT" GROUP PRACTICE IN KEMEROVO

ALTAI KRAI OBLAST
- POLYCLINIC N4 (30.003)
- POLYCLINIC N9 (30.003)
- CENTRAL CITY POLYCLINIC (30.003)
- HOSPITAL N10
- NOVOALTAISK CITY HOSPITAL
- TROITSK CENTRAL CITY HOSPITAL

NOVOSIBIRSK OBLAST
- EMERGENCY MEDICAL CARE CLINIC
- "ASOPO-ZHIZN" INSURANCE COMPANY AND CITY POLYCLINIC (30.001)

TOMSK OBLAST
- CITY POLYCLINIC N1
- CITY POLYCLINIC N10
- RURAL PHYSICIAN STATION IN PERVOMAISKY RAYON
- RURAL PHYSICIAN STATION IN ZONALNY,TOMSK RAYON

TVER OBLAST
- CITY HOSPITAL AND POLYCLINIC N1
- CITY HOSPITAL AND POLYCLINIC N6
- KALUGA OBLAST
- CITY POLYCLINIC N1

2. IN-PATIENT PAYMENT MODELS:

TOMSK OBLAST
- OBLAST CLINICAL HOSPITAL (30.005)
- CITY HOSPITAL N3

TVER OBLAST
- CITY CHILDREN'S HOSPITAL

KALUGA OBLAST
- CITY EMERGENCY HOSPITAL
- CITY CHILDREN'S HOSPITAL AND NETWORK

3. MANAGED CARE-FULLY INTEGRATED MODEL (HMO-LIKE)

KEMEROVO OBLAST:
- TISSUL RAYON
- KEDROVKA RAYON

NOVOSIBIRSK OBLAST
- CHEREPANOVO HOSPITAL

TVER OBLAST
- CENTRAL RAYON HOSPITAL AND POLYCLINIC, VISHNY VOLOCHOK RAYON
- CENTRAL RAYON HOSPITAL AND POLYCLINIC, VISHKINOVA RAYON

KALUGA OBLAST
- CITY HOSPITAL AND POLYCLINIC N5
- CENTRAL RAYON HOSPITAL AND POLYCLINIC, FERZIKOVSKY RAYON
- CENTRAL RAYON HOSPITAL AND POLYCLINIC, MALOYAROSLAVSKY RAYON

GRANT PROGRAMS:
- TULA HMO MODEL (400)
- LANGMED HEALTH INSURANCE PLAN (402)

4. INTEGRATED COSTING MODEL:

TOMSK OBLAST
- OBLAST CLINICAL HOSPITAL (30.005)
- CITY HOSPITAL N3

5. RESTRUCTURED POLYCLINICS INTO GP OFFICES:

KEMEROVO
- MEZHDURECHENSK CITY POLYCLINIC
- BELOV CITY POLYCLINIC
- BEREZOVSKY CITY POLYCLINIC
- BEREZOVSKY FELDSHER STATION
- ANZHERO-SUDZHENSK CITY POLYCLINIC
- KRASNIN DISTRICT HOSPITAL
- FELDSHER STATION IN YURGA RAYON
- "GIPPOKRAT" GROUP PRACTICE IN KEMEROVO

ALTAI KRAI
- POLYCLINIC N4 (30.003)
- POLYCLINIC N9 (30.003)
- CENTRAL CITY POLYCLINIC (30.003)
- HOSPITAL N10
- NOVOALTAISK CITY HOSPITAL
- TROITSK CENTRAL CITY HOSPITAL

NOVOSIBIRSK OBLAST:
- "ASOPO-ZHIZN" INSURANCE COMPANY AND CITY POLYCLINIC (30.001)

TOMSK OBLAST:
- CITY POLYCLINIC N1
- CITY POLYCLINIC N10
- RURAL PHYSICIAN STATION IN PERVOMAISKY RAYON
- RURAL PHYSICIAN STATION IN ZONALNY, TOMSK RAYON

GRANT PROGRAMS:
- ST PETERSBURG GP OFFICE ESTABLISHED (404)

6. MULTI-LEVELS OF HOSPITAL CARE MANAGEMENT:

ALTAI KRAI OBLAST
- NOVOALTAISK CITY HOSPITAL

7. FINANCIAL MODELING METHODS:

ALTAI KRAI OBLAST
- KRAI HEALTH COMMITTEE

Output 4: Health Management Information System Output

Under the Zdrav*Reform* Program, computers were procured for 18 Siberian facilities to support the clinical and administrative decision needs of these reform models with approximately 200 personal computers (PCs). The sites provided official Equipment Acceptance Acts to show that the equipment placed in the facilities had been formally registered as part of the real property inventory of the sites. All computers purchased under the project have been installed. Approximately 35 of the 104 Russians who participated in the development of the Zdrav*Reform* Working Models worked on the financial information systems software for Territorial Health Insurance Funds, and an additional 18 worked on the clinical patient records software.

Task 108 -- CD-ROM Library

In order to address the recognized lack of professional Western health care literature available in Russia, a resource library of reference literature on health economics, health management systems and emerging clinical practices was created under the ZdravReform Program. The aim of this activity was to provide Russian policy leaders, medical educators, and health sector professionals with new ideas, concepts, and management approaches from the Western experience.

Translations of 6,250 pages of text from 310 articles and books, selected by a Russian-American editorial board of 21 academicians, professionals and physicians, have been put onto a CD-ROM, with user-friendly navigational software. See Appendix 9 for list of documents included in the CD ROM.

The library is organized into 7 major categories:

1. New methods of clinical care;
2. New methods of quality management techniques;
3. The program of informatics in health management;
4. Discussion of health policy and legal reform;
5. New methods of managing health care organizations;
6. New methods of financing health care benefits; and
7. New types of organizational structures for integrated delivery systems represent the 7 topic areas for the library.

2,000 CD-ROM disks have been made available to leading research organizations, universities, professional associations, health ministries, and health care leaders throughout Russia. The 18 month activity involved work by 48 professional consultants in both the United States and Russia. Full copyright waivers were obtained for all included materials.

Task 109 -- Territorial Fund System

This task funded the development of a system to allow Territorial Funds to better manage the beneficiaries of compulsory health insurance.

The fundamental shift by Territorial Funds from departmental financing toward capitated contributions and financing of facilities under contractual relationships requires very new information systems both to help track all policy holder transactions as well as to serve newly defined measures of strategic performance.
The system of Fund management through the use of insurance companies requires an extremely complicated system of financial transactions. Thus monitoring compliance between the parties of transactions is very well suited to the adoption of computerized tracking systems.

"The Insurance Benefits Manager" is a series of software programs developed by Russian programmers, economists, and insurance administrators. Referred as THIF, the programs are based on 2 groups of experiences: 1) guidelines developed by the Federal Fund for mandatory health insurance; and 2) practical experience gained in implementing

insurance reform during the past four years in Kemerovo's Territorial Fund. The first versions of THIF were developed and installed in 40 Territorial Fund branches throughout the Kemerovo Oblast between 1993 and 1995. The new software is a collection of applications available in the public domain to all who request it. The programs are a series of linked relational databases which help:

1) insurance companies generate individual health insurance policies;
2) accountants keep records of premiums and payments due
3) accountants pay medical providers for their services
4) regulators license and accredit medical facilities
5) actuaries set rates of reimbursement and capitated contributions

The programs include source code for development and maintenance of all linked data files, menu-driven data input screens, and a series of standard screen and hard-copy reports. The system offers 6 integrated program modules.

I. The *Policy Manager* allows for automated generation of beneficiary and insurance company membership documents. Policies may be generated at the point of service (a polyclinic or hospital) or in centralized branch offices of Territorial funds and/or insurance companies. The software will enable the fund/insurance company to maintain a perpetual record of its covered beneficiaries. Current manual systems result in error rates of 70% in adjudicating provider payments with responsible financial parties. This database will record vital demographic, clinical and financial information on 2 million oblast enrollees with the compulsory medical insurance program. Use of software by funds, insurers, and medical care providers will allow for records to be perpetually updated with the most current information. This will facilitate a significant reduction in transaction error rates and reduce the number of back office personnel required to administer the compulsory insurance program.

II. The *Premium Manager Module* helps automate the processing and tracking of employer based compulsory medical insurance contributions as well as local administration contributions for non-working beneficiaries of compulsory medical insurance. The current system of accounting for MHI contributions results in collection rates significantly lower than expected. As enterprises become more viable, automated and standardized collection procedures will increase the flow of funds into the health sector. The software provides for organized collection efforts on delinquent accounts. This system is merged with the policy manager to identify financially responsible parties.

III. The *Contract Management Module* supports the Territorial Fund and/or medical insurance companies to administer their financial agreements with medical service providers. This payment adjudication software helps the fund and/or insurance companies process medical care claims, fund-holding expenditures, and capitation payments in all of the new financial mechanisms. The system will help compile all clinical utilization statistics necessary to monitor and measure the workability of all new provider service agreements. The system helps health committees, facilities and insurance companies in their transition from budget allocations toward payments through service agreements.

IV. The *Licensing and Accreditation Module* automates the currently manual processes of tracking hospitals, polyclinics, diagnostic centers, and other medical care providers. These medical institutions receive legal authorization and regional regulation to provide very specific levels of medical services. In the transformation to insurance based medicine, payment to medical providers is often determined according to levels of legal licensees. The software links the interest of medical facilities, health committees, territorial funds and insurance companies through standardizing the use of a single registration database. Current information on regulating the practices of medical care providers is enhanced through information provided by this software.

V. The *Financial Modeling and Rate Setting Module* provides for a synthesis of information provided through modules I and II. Large databases describing population demographics, provider and institutional demographics, financial and utilization information are manipulated within this software in order to conduct multivariate scenario modeling utilized by medical insurance actuaries.

This Insurance System was originally planned to process data on approximately 2 million beneficiaries in the Kemerovo Oblasts. That target will not be achieved until at least until 1998. All policy and procedure manuals, database descriptions, and extract programs are complete and have been edited and formatted. The new software concept has been submitted to the Federal Fund for registration.

The 18 month term for procurement has delayed completion of all sub-system integration until beyond the current end date for Zdrav*Reform*.

Task 112 - Clinical Patient Records

Delays in computer procurement resulted in a smaller number of full production system installations. Initially the Zdrav*Reform* Program expected to install a fully operational clinical patient records system in each of the 9 polyclinics that integrate quality improvement indicators and new payment models. By September 1996, installation of production software was completed in 5 sites. These 5 sites will have a local area network (LAN), with 5 personal computers (PCS) to accomplish the following functions:

- 1 PC used to register patients;
- 1 PC used to support payment, monitoring, and adjudication;
- 1 PC used by statistician to prepare various service utilization reports;
- 1 PC used as the LAN central server; and
- 1 PC used by Chief Physician to assess physician productivity and quality performance.

These clinical record systems support care to approximately 200,000 citizens in the catchment areas of the 5 polyclinic pilot sites.
The Zdrav*Reform* Program provided personal computers to sixteen general practice offices: six in Barnaul, six in Kemerovo and four in Tomsk sites. This processing capacity is expected to enhance both the clinical and administrative operations of these new GP offices. Computers were delivered to the Russian counterparts in May and June 1996.

Kemerovo polyclinic software is complete and installed in 2 pilot sites; Polyclinic 12 and Polyclinic 5. All computers are installed in other pilot sites. Training on software occurred throughout the remainder of 1996. A Demonstration Disk of software is complete and available as both Russian/English version. Polyclinic 12 has agreed to construct a detailed database on 15,000 patients covered under new fundholding contracts.

Barnaul software is in production at Polyclinic # 9, and at the Troitsk pilot site. Computers are installed at Novoaltaisk pilot site; but the grantee has decided not to proceed with a fundholding patient registration program. Computers for General Practitioners are being held by the local Health Committee for future distribution.

Clinical Patient Record System

"The Polyclinic Manager" was developed under Zdrav*Reform* by Russian programmers, economists, physicians and administrators. It is based on earlier software developed under the name "ARENA." The first three versions of ARENA were developed and installed in over 500 polyclinics throughout Russia between 1980 and 1994. The new software is public domain software available to all who request it. The program is a patient-oriented relational database which helps:

1) physicians manage the clinical care of their patient panels;
2) chief doctors schedule and manage medical staff resources;

3) polyclinic administrators schedule and manage patient visits;
4) accountants reconcile all forms of payments to the polyclinic;
5) economists analyze detailed per capita utilization and costs; and
6) patients to participate in improving their health status.

The program is written in Paradox for Windows. It supports either network or free-standing PC applications. Hardware requirements include at least a 486 processor, 8 megabytes of RAM and 540 Mb of hard disk. The program includes the source code for development and maintenance of all linked data files; all menu-driven data input screens; and a series of standard screen and hard-copy reports. The system offers 6 integrated program modules.

I. The Patient Registration and Appointment Module allows for automated appointment generation for all standard Russian clinical departments. Appointments may be generated by and for patients, primary care physicians, specialists, hospital-based physicians, para-clinical staff, and diagnostic departments. Information is entered once and then available to all users concerning a particular patient's demographics, insurance coverage, special medical condition; work status, disability status, assigned primary care physician; and any relevant financial information. Standard reports include comparative physician panel reports, appointment availability reports and clinical department productivity reports.

II. The Clinical Statistical Module accounts and summarizes all patient visit encounters. Each patient's file contains a history of each medical service encounter of the patient. Data on primary care visits, specialty referral visits, diagnostic tests and therapeutic para-clinical encounters, related prescriptions, operative procedures and hospital admissions are all entered into this sub-system. Information includes date of service, diagnosis, procedure code, test code, treatment code, ordering physician code and accountable physician code. All of the above data can be sorted and retrieved by keying on any particular field. Standard reports include comparative patient level, departmental and physician level utilization reports. Custom reports may be created for actuarial trend analysis and cross-sectional comparative utilization analysis.

III. The Financial Management Module allows for the input and tracking of unit cost and price information at the intermediate service level, the encounter level, completed case level, and capitation level. Cost information is included through the development of relevant unit cost tables, medical economic standard tables, and step-down budget tables. Price information is included through automated fee schedules, and other insurance based payment provisions. The major function of this module is to support new methods of payment for ambulatory care. The program creates standard management reports required to administer polyclinic fund-holding, capitation, fee-for-service or any managed care contractual permutation. Financial information is linked to the patient files and clinical utilization files in order to create custom management reports on financial performance of physicians, clinical departments, employers or insurance intermediaries.

IV. The Clinical Outcomes Management Module provides for automated tracking of compliance with a standard set of ambulatory quality indicators. This set of files and reports utilizes the clinical statistical sub-system to identify medical activity associated with desired preventive care. This module compares such activity with the appropriate population registered in the Patient and Appointment module. Standard reports include the comparison of actual encounters with desired encounters specific to patients, accountable providers, insurance companies, employers or polyclinic catchment areas. The sub-system includes a standard set of ambulatory quality indicators, but the program supports the development and compliance monitoring of custom indicators as well.

V. The Electronic Medical Record Module supports the automation of test results reporting, generation of a patient complaint and problem list, and electronic mail for progress notes, referral notices, physician to physician communication, clinic to insurance company communication, and

electronic claims submission. The previous four modules are interconnected and a mandatory part of the Polyclinic Manger System. This module is optional. It is best suited for a network installation. The subsystem provides for expedited communication of clinical, social and financial information among providers and payers. The sub-system supports automated language protocols (Health Level - 7) links with laboratory, x-ray, pharmacy, hospital discharge and insurance carrier systems. It also acts as an interface and security port with commercial e-mail and Internet sites.

VI. The Resource Management Module supports physician scheduling, treatment room scheduling, operating room scheduling and their associated productivity management. The subsystem tracks the work capacity of each clinic department and treatment center as well as the actual use of these facilities. Standard reports demonstrate the percent of capacity which is actually used. This system can be used to track the productive use of expensive equipment as well as medical facilities. Standard reports also define time trends for peak use, over-booking, and unproductive time due to room closure or repair and maintenance requirements. This module is also optional and best used by a combined hospital-polyclinic enterprise.

Task 111 -- Operations Analysis Group

In the summer of 1995 two groups of people (a total of 19 participants) went to the United States on study tours that focused on analytical techniques for managing hospital resources and investment decisions. They studied medical information systems as a basis for financial decision making. Several of the participants did case studies which applied what they learned.

Svetlana Babarikina in Kemerovo led 3 of the studies:

- mammography as alternative to manual examination of mamma;
- comparing the Runo diagnostic express method efficiency for monitoring health status and screenings;
- evaluation of the anti-flu preventive measure efficiency versus total treatment costs;

Tatiana Gabdrakhimova in Tomsk oversaw one case study:

- development of contract monitoring system; and

Two case studies were performed in Moscow:

- development of Financial Modeling Manual;
- development of WWW Home Page format.

Task 113 and 114 -- MIS Plan for Tver/Kaluga

Russian consultants completed analysis and reports after initial visits to the Oblasts, and with the World Bank team in the latter part of June. The Bank team encouraged Tver and Kaluga leadership to work closely with ZRP consultants. However, a final information plan and list of commodity procurement specification was not completed because of the differing visions of all of the parties involved.

Output 5: Dissemination and Roll Out Output

Budget reductions in 1996 have severely limited the scope and depth of dissemination/roll-out activities in the Russian Program. The following actions have been taken to optimize the limited resources available for dissemination purposes:

Printing of Zdrav*Reform* Products

To help ensure replication and sustainability of the working models and other technical programs completed under the Zdrav*Reform* Program, a major priority for 1997 was the editing, formatting, and printing of selected documents produced. Upon printing of the documents, they will be turned over to Kaiser Permanente International[1] for dissemination.

Former ZdravReform technical experts, USAID, and Abt Associates staff determined a list of thirty-eight ZRP documents which would be valuable for dissemination around Russia. Abt Associates held an open competition in Russia to choose organizations to edit and format these documents. Contracts for both the editing and formatting work were signed with Neotech, Inc. Several of the documents selected were first technically edited by ZRP experts before being turned over to Neotech for standard editing and formatting.

Immediately following the competitions for editing and formatting, Abt Associates staff held a third open competition to choose a publishing company to print the required number of documents. Based on the price quotes received and budget restrictions, Abt Associates, in collaboration with USAID Moscow, reduced the number of documents to be printed to twenty-eight and significantly reduced the number of copies of these documents. See Appendix 10 for the original list of documents to be printed and the subsequent modifications.

[1] the contractor who will do follow-on work to the ZdravReform contract.

Pilugin International Ventures, Inc., an American publishing house doing business in Russia, was chosen to do the printing work. A subcontract was negotiated with them and submitted for approval in early May.

Task 441 -- Russia Dissemination Conference

On November 21-24, 1996, the Institute for Advanced Studies of Health Care and Insurance Managers (AVANTA) conducted the All-Russia Conference entitled "Health Care Reform in the Russian Federation: Outcomes of Russia-US Cooperation." The purpose of the conference was to disseminate the ideas and materials of the Zdrav*Reform* Program as well as other USAID funded programs. The meeting was held in the Moscow Oblast, and 359 people from around Russia attended. The participants included: physicians, health managers, employees of mandatory health insurance funds and insurance companies, as well as others involved in Zdrav*Reform* activities. Sessions were broken into lectures and smaller discussion groups. In addition, there were 5 booths with information available, 3 from medical publishers, one with the 1st ZRP CD ROM, and one with grant products.

A great deal of interest was shown in all aspects of the grants program, from the administrative workings of awarding grants to the types of projects performed under the existing grants. Apart from all of the information about the grants program distributed at the conference, an additional 40 requests for further information was taken and later sent out.

A reporter who described the conference in a Russian newspaper commented, "There was a general feeling that good seeds have been planted, much has been done, but the main work is still ahead."

Task 194 -- Almaty Conference

The Zdrav*Reform* Regional Technical Conference, held December 14–15, 1995 in Almaty, Kazakstan, disseminated information about Program progress and lessons learned and provided an opportunity for cross-fertilization of ideas among professionals who are engaged in health reform and from the countries of the New Independent States (NIS). More than 50 papers on various aspects of financing, management, and organization reforms were presented to an audience of 213, including more than 160 practitioners of reform from Kazakstan, Kyrgyzstan, Moldova, Russia, Tajikistan, Turkmenistan, Ukraine, and Uzbekistan, and personnel from international assistance organizations.

The papers presented at the Conference covered a broad array of reform initiatives in various stages of execution. This permitted Conference participants to maximize learning about what has worked, what obstacles have been encountered and whether and how they have been overcome, and what ideas have been proposed but are yet to be implemented. Much cross-fertilization took place, since different countries and localities are trying different approaches to similar problems or are at different stages of execution. In addition to the Conference's three plenaries and fifteen concurrent sessions, participants took full advantage of the time reserved between sessions for informal discussions. Two evening receptions held in conjunction with the Conference facilitated informal meetings, as well.

This Conference marked the first time many of the reform practitioners from around the NIS had participated in a voluntary association of health professionals, without central direction, where they were free to exchange technical information and views. Few, if any, of the participants received an official mandate on the content or delivery of their presentations. Establishing the precedent of a professional meeting with open technical exchanges represented an accomplishment in its own right.

Task 172 -- AIHA Annual Meeting/CQD Workshop

Zdrav*Reform* presented a talk on "Quality Assurance in New Payment Methods*"* on October 17, 1995, as part of the AIHA Third Annual Conference held in St. Petersburg. The theme of the conference was "Managing Quality for Healthy Outcomes." Zdrav*Reform* organized several sessions within the conference.

The ZdravReform seminar explored how contacts between purchasers and providers of health services are being used as a mechanism for health sector reform. By making more explicit the accountabilities of both purchasers and providers of healthcare, performance is expected to improve. One important accountability of these new contracts is the assurance of the quality of health services being purchased. The panelists addressed how England, the United States, and Russia are addressing this issue of quality assurance within their purchaser-provider contracts.

The panel introduced an outline of various national perspectives on purchaser-provider relations and opened the floor for a question and answer session. The speakers included James Rice, Country Director of ZRP, Pam Garside, a partner of Newhealth London, and Ludmilla Isakova, of the Department of Health Economics of the Kemerovo oblast.

Observations as a Result of the discussions included:

- The Russian Health Professionals and leaders felt quite comfortable discussing the NHS (National Health Service - British health organization) situation as they saw many parallels with their own.
- The audience was particularly interested in the General Practitioner "fundholding" concept and mechanism as a method of shifting resources from secondary to primary care in Russia which was felt very necessary.
- Perceptions and definitions of quality vary enormously, even within countries.

- The way in which "purchasers" of care stay informed on quality and service issues was of considerable interest.

- The Russian participants had a high level of concern about avoidance of "corruption" of the system -- not necessarily financial corruption, but the way in which an internal market is regulated and monitored to avoid incentives, particularly for professionals.

On Sunday, October 15, the day before the conference began, Abt Associates held a grantee meeting in St. Petersburg. The meeting was designed to be an informal gathering for the grantees to meet each other and share ideas and experiences. Grantee responsibilities (financial and technical reports, etc.) were also be reviewed. All grantees were invited, and Abt offered to pay for one participant from each grant to attend the AIHA conference.

Task 198 -- Moscow Managed Care Model Seminar

The ZdravReform Program collaborated with Russian organizations to plan and conduct a one week seminar in June 1995 that combined lectures, small group discussions and case study exercises. The seminar discussed 1) all aspects of establishing and successfully operating general practices and, 2) new provider contracting arrangements that encourage shift of care from hospitals to general practice ambulatory care sites and enhance the potential for better quality and more efficient care.

Co-sponsoring organizations included: Federal Fund, Moscow Health Insurance Association, The Moscow Mandatory Health Insurance Fund, and the Medstrakh Insurance Company. Costs for the seminar were borne 50% by Zdrav*Reform* and 50% by the Russian consortium.

Task 155 -- Providing Input into Policy Processes

The task was targeted as a repository of miscellaneous support to the USAID Mission as they worked to encourage the Duma and GKI to collaborate on a new policy think tank institute in Moscow. ZRP staff provided assistance designed to encourage the exchange among health sector leaders of Russia of practical information and experiences in health insurance reforms of the United States, Germany, England, Netherlands, and Israel. Specific activities included:

1. Planned, developed and conducted an international seminar for 100 senior health sector leaders from around Russia on principles and practices of health insurance reforms. Work performed was in cooperation with the Federal Fund. The seminar relied on panel discussions that highlight practical lessons being learned from countries involved in reforms relevant to Russia. It provided for extensive interaction among panelists and audience to encourage a free-flow of ideas that would stimulate Russian policy leaders about useful ways to enhance their health sector reform initiatives. It generated written recommendations on:
    - interaction between Territorial Funds for Mandatory Health Insurance and private insurance carriers;
    - approaches to develop risk adjusted capitation fund allocations from Territorial Funds to private health insurance companies;
    - methods of payment for hospital care;
    - methods of payment for ambulatory care;
    - methods of "Managed Care" to enhance the quality and cost-effectiveness of care:
    - methods of costing medical benefits package(s); and
    - possible legislative and regulatory actions to improve Mandatory Health Insurance;

Proceedings from the seminar were disseminated to healthcare leaders in Russia. It provided a forum for USAID supported experiences in Siberian health sector reforms to be shared with others.

2. Provided technical support to the Public Health Institute of the Ministry of Health to identify the most useful papers to be offered at the Moscow Policy Conference in December 1995;

3. Provided economic support to compile and edit these papers into a "Policy Brief" and to distribute it to the interested health policy reformers;

4. Funded a one-week visit to St. Petersburg by Dr. Eugene Feignhold, former president of the American Public Health Association. Dr. Feignhold participated in a Public Health Policy Seminar sponsored by the Public Health Institute from June 21 to 26, 1995;

5. Provided partial funding for the development of a written report that summarizes the major conclusions of the St. Petersburg AIHA conference via a subcontract with the organizers of the conference; and

Task 193 -- Siberian Public Health Association

In 1995, the Siberian Public Health Association (SPHA) developed and produced educational materials and events to enhance the managerial and leadership capabilities of health sector executives and physician leaders of Siberia. This strengthening of managerial capabilities was judged an essential prerequisite to the sustainable implementation of the several reform projects and working models defined in the 1995 Country Action Plan approved by USAID/Moscow.

Under this subcontract, SPHA planned, developed and administered a seminar during the Fall of 1995 that served 110 managers throughout Siberia. In the context of the seminar, the SPHA designed and conducted focus groups and surveys among administrative and physician leaders regarding health sector reform trends and the management knowledge, skills and attitudes most needed to successfully address these challenges.

The seminar served as one step in the process of developing and enhancing a strategy for meeting the continuing education needs of public health managers of Siberia.

Task 173 -- Professional Meeting of Nursing Associations

On June 27-28, 1996, the All Russia Nurses' Association (ARNA) and World Vision, with administrative support from the Ministry of Health of Russia, held the Third Russian National Conference on Nursing in St. Petersburg. The Conference brought together 147 delegates -- head nurses of Russian territories and directors of nurses' colleges (traditionally called "medical schools" in Russia) -- representing 44 subjects of the Russian Federation.

The Conference Resolution legitimated ARNA's status as the nationwide nurses' association representing and advocating interests of nurses throughout Russia.

ARNA proposed systematic measures that would substantially improve social and economic status of nurses. Measures included: new incentives and improved compensation for members of nursing schools' faculties; mandatory unobligated insurance of professional risks and paid immunization for nurses in hematology, surgery, and intensive care units; increased salaries for lower-level medical staffs; prolonged vacations for head nurses of health care facilities.

To address professional improvement opportunities, ARNA arranged training for 40 head nurses of Russian regions at the Department of Higher Education in Nursing at the St. Petersburg Medical Academy. On recommendations from ARNA and regional associations, 35 individuals were awarded Diplomas for Active Development of Nursing in Russia.

Task 440 - Healthy Communities Conference and Guide

Zdrav*Reform* helped organize a two-day *conference on "Healthy Communities."* The conference was designed to share the international experience in Healthy Communities, as well as the experience of three Russian cities who received grants under ZRP, with other cities around Russia in order to stimulate more interest and activity for health promotion programming in Russia. Both American and European experts were brought in to help share their experiences and to help Russians adopt the concept of Healthy Communities to their own environment.

The following activities were accomplished:

1. Provided Russian language reference materials discussing how to design and implement a "Healthy Cities Program";
2. Conducted a 2-day seminar in Izhevsk on practical concepts and tools needed to establish a successful "Healthy Cities Program"; and
3. Prepared a report that summarizes the results of the two-day conference on a format that is suitable for broad scale dissemination to other cities in Russia.

In addition to the conference, Zdrav*Reform* supported the development of a *manual* designed to help Russian develop "Healthy Cities Programs" (HCP) in their regions. Five hundred copies of the manual were prepared and disseminated to interested communities around Russia. This manual provides a practical, and user friendly collection of step-by-step concepts, activities and tools, that can help local cities design, develop and implement a HCP. It combines materials from WHO, the Russian Ministry of Health, three ZdravReform grantees, and the US Healthy Communities Program.

Task 174 -- Publish AUPHA Special Edition

The Zdrav*Reform* Program supported the Association of University Programs in Health Administration (AUPHA) in the production of a special issue of their journal to cover health care reform in the Russian Federation. Zdrav*Reform* funded the English version of the journal and contracted with a local firm for the production of the Russian version. Additionally, ZRP funded the translation into Russian of a previous issue done for Central and Eastern Europe.

III TRAINING

During 1995 and 1996, Zdrav*Reform* supported the training of over 2,700 government officials, health professionals and local leaders in various aspects of health sector policy reform and improvements in health delivery and financing systems and organization. In addition, hundreds of health professionals were trained under the training programs supported by the Small Grants Program.

Task 115 -- IS Support for Ekaterinburg

A study tour was organized and funded for two senior health leaders from Ekaterinburg to provide an intensive learning experience in the areas of (1) practical information systems and, (2) materials needed to improve the performance of clinical and administrative decision-making in their health sector.

The participants included:

Mr. V. A. Kozlov, engaged in the in-patient care reform, was primarily interested in organization of managed post-hospital care. Mr. S. L. Leontiev, head of the MHI fund, was interested in information technologies in health care, its organization, management and post-hospital treatment.

The study tour took place in Boston in October 1995. It was organized by Josh Coburn of Abt Associates. Leontiev focused on new information systems design and operation of health insurance; Kozlov concentrated on care management for cardiac patients. For two weeks, the participants attended a program that emphasizes practical review of modern tools, materials and information provided by actual private health care institutions. Specific topics addressed in the two areas of concentration include:

Information Systems

* Premium collection protocols, policies, systems and procedures;
* Cash management of premiums collected;
* Provider payment systems;
* Physician practice patterns monitoring and quality assurance;
* Record keeping systems linking doctor, hospital and purchaser of health care;
* Reporting procedures and systems from insurance company to employers and to the public via modern "report cards."

Cardiac Care Management

* Clinical Care maps as a general concept;
* Modern diagnostic and treatment protocols for cardiac patients, with special emphasis in acute myocardial infarction and bypass surgery;
* Discharge planning procedures, protocols, materials;
* Cardiac care bundled price contracting with HMO's and insurance companies;
* Cardiac rehab processes to reduce length of stay, increase quality of recovery, and save money;
* Post hospital care processes and patient/family responsibility.

The participants held a series of meetings and workshops with the Oblast health leaders, scientists and physicians to share the knowledge acquired. They are planning to form a working team for development of an in-patient care reform concept.

Task 121 and 122 -- TQM Training in Santa Cruz and Novosibirsk QI/UR Workshop

In preparation for CQD projects, Zdrav*Reform* trained 18 medical leaders as CQD trainers in Santa Cruz, California during Q1 1995. These trainers then helped train 50 medical leaders in CQD practices during a Q2 seminar in Novosibirsk. This core of CQD leaders was then active in the design and

implementation of the five CQD pilot. Extensive reference materials on CQD have been developed and distributed to 100 medical leaders associated with the five CQD pilot sites.

Task 145 -- Finance Training (UK Trip)

The purpose of this trip was (i) to train Russian health economists and service delivery experts in principles, major components and methods of payment for outpatient care in the U.K.; and (ii) to give the participants a practical understanding of the U.K. experience in designing and implementing "Fund Holding" for General Practitioners as a means of:

- injecting greater control over health care use to primary care practitioners;
- developing new economic incentives to avoid unneeded referrals to specialists and hospitals;
- encouraging greater consumer choice and power over their own health status;
- encouraging GPs to focus more attention on health promotion and disease prevention.

A group of U.K. experts discussed the following major topics with the participants:

- how GPs "enroll" patients, upon which Fund Holding revenues are based;
- how Fund Holding amounts of money are calculated and distributed;
- common line-item costs for GP Fund Holder;
- variations of Fund Holding schemes for individual GPs, groups of GPs, GP and consultant mixed groups;
- how the GP Fund Holders manage quality of care and economic risks of care;
- how referrals to and relationships with consultants and hospitals are managed;
- critical success factors for GP Funding Holding.

Task 146 -- Finance Training (HMO Trip)

There were two independently oriented tours that went out to Minneapolis and San Francisco. There were a total of 19 participants. The goal of the tour was to study the structure and operations of HMOs in America and assess the applicability to Russia as an alternative in providing primary care.

Task 148 -- Finance Training (DC Study Tour)

A group of 24 Russian participants, accompanied by ZRP/Moscow's Health Economists, traveled to the Washington, DC Metropolitan Area to attend a 2-week comprehensive Study Tour. Topics covered include management and payment of independent practitioners, operation of modern health insurance companies, and integrated health plans.

The Russian participants were divided into two subgroups during portions of the tour:

Group A from Moscow was provided with practical information and tools related to the development, management and payment of independent practitioners. They had periodic visits to physician practices and HMO clinics.

Group B from Oblasts throughout Russia was provided with practical information and tools related to the operation of modern health insurance companies and integrated health plans like HMOs. They worked with representatives of "Blue Cross", HMOs and HCFA regarding all aspects of health insurance program design, administration, quality assurance, claims processing, and related MIS.

There were also structured opportunities for the two groups to attend common sessions, and to meet for evening discussions regarding ways to best apply the lessons and principles shown in a Russian setting.

Task 162 -- Kemerovo HMO Model Workshop

An HMO Workshop took place in Kemerovo in April 1995. There were a total of 31 participants. The goal was to review the HMO concept and how HMOs operate and to develop models appropriate for Russia. Case studies and small groups were engaged. In a presentation given by Jim Rice, he stated that the purpose of this workshop was to outline the "ideal" delivery system, contrast the ideal the "real" situation in Russia, and define key success factors to move toward the ideal.

The following topics were discussed:

- Integrated Levels of Care in Organized Delivery System
- How Quality is Measured
- Obstacles to Better Quality in Russia
- Quality Assurance
- Management Structures
- Critical Factors for Operational Success
- Governance of Integrated Health Systems
- Critical Success Factors for HMOs in Russia and Obstacles to this Concept
- Origins of an HMO

The training officer interviewed participants who all reflected a high degree of motivation and satisfaction with the workshop. A number of models were developed as a result of the workshop.

Task 163 -- Provider Payment Manual (Preparation Meeting)

The purpose of this task was to prepare several technical documents for presentation and discussion at a one-day workshop on the content and organization of the Reimbursement Manual, a detailed step-by-step guide to developing and implementing individual approaches to payment of health care services provided by physicians and hospitals. Outputs from the meeting included a plan of action, timeline and budget for the manual. The manual was put together in response to interest and demands of NIS counterparts for a payment systems manual outlining options and step-by-step approaches to implement individual systems.

The workshop was held on 1 June, 1995 for representatives of interested donor institutions and technical experts to discuss and recommend a list of technical topics and a format for their presentation in the Manual.

Grant Study Tours

In addition to the above trainings, several study tours were funded under the grants. These are summarized in the table below.

Task #	# Participants	Organization	Topics	Destination
400	8	Tula-Albany Health Insur. Co.	HMO	US
411	1	Central Medical Unit 122	Healthcare Delivery	Germany
414	2	Sverdlovsk Territorial Fund	Post Hospital Care/MIS	US
415	3	Izhevsk Mayorate	Healthy Communities	US
	2		Healthy Communities	Croatia
418	2	St. Pet. Medical Academy	Curriculum Development	US
419	2	Rostov Regional Fund	Insurance	US
421	5	Khabarovsk Regional Fund	Leadership Development	US
425	17	Academy of Nat'l Econ.	Insurance	US
427	5	Novosib. State Academy 1	Leadership Development	US
437	2	Tula Territorial Fund	HMO	US

IV SMALL GRANTS PROGRAM

In ZRP's six main oblasts and in other oblasts, targeted grants have been made to Russian organizations with the capacity to promote and implement innovative reforms. The ZRP grants program helps leverage the practical experiences from rayon-based working models in three strategically important ways:

1. Working Model Component Development -- grants are made to fund innovative projects that contribute to the development of methods and tools needed for successful implementation of working models (Altai Krai: private primary care practices, multilevel system of in-patient care; Kemerovo: outpatient DRG system; Novosibirsk: private family practices; Tomsk: alternative methods of payment; Tumen: private insurance company affiliated with LukOil; Tula: HMO-style system)

2. Leadership Capacity Building -- grants are made to fund leadership development initiatives to help assure that there will be a cadre of managers capable of using the new methods and tools; and

3. Lessons Dissemination -- grants are made to fund publications and professional associations to conduct seminars to help disseminate reform-intended ideas and the lessons being generated from Russian-American teams working on pilot projects.

A. Executive Summary

Abt Associates Inc. began work on the Small Grants Program in December 1993 to "develop and manage an innovative grants program to support experimental pilot projects, applied research and special studies that would inform health related personnel in the NIS and A.I.D. on alternative approaches to furthering health sector reform." The program was completed in December 1996 with over two million dollars awarded to thirty-eight Russian institutions in nineteen regions around Russia and another half million dollars given to the grants in terms of technical assistance. Grants were given both to organizations within ZRP's geographical focus areas (GFAs) to complement the working models already in place and to other regions to support additional Russian led efforts and foster the growth of new ideas around the country. The priority themes for the Zdrav*Reform* Grants Program mirror the goals of the overall USAID supported project:

Priority Theme	Grant Money Allocated	# of Grants
Establishment of Free-Standing General Practices	$264,480	4
Development of New Payment Methods	$434,957	8
Dissemination and Leadership Development	$697,540	12
Healthy Lifestyle Promotion	$385,017	8
Efficiency Improvement of In-Patient Care	$265,234	6

Refer to Appendix G1 for additional information on each of the grantees.

One of the greatest advantages of the small grants programs is that with relatively small amounts of funds, results can be produced quickly with good chances for sustainability since they are already understood and owned by the local people. Examples of results accomplished through the Zdrav*Reform* Small Grants Program include:

- 6 private primary care practices have been established;
- 8 innovative training programs in healthcare management have been developed and an umbrella organization "the Russian Association of Health Care Management Training Programs" has been formed;
- 6 hospitals and polyclinics have instituted new payment methods;

- 7 hospitals and polyclinics have implemented quality improvement measures;
- The concept of "Healthy Communities" has been introduced into 3 Russian regions with a strong emphasis on roll-out to other regions;
- 645 articles written on healthcare reform
- 3 Professional Associations established

See Appendix G2 for complete information on accomplishments of each of the grantees.

The remainder of this paper is organized as follows. In Section II, a history of the Small Grants program is provided. In Section III, the procedures involved in running a grants program are presented. In Section IV, actual success stories and problem cases that occurred in the program are discussed. Finally, in Section V, the lessons learned working on this program are discussed and recommendations for running a future grants program are given.

B. History/Evolution of ZRP Small Grants Program

Abt Associates Inc. began work on the Small Grants Program in December 1993 with an overall budget of $1.2 million (with average awards approximately $50,000). David Boyd was the Grants Manager and led the work on this program. The first task of the Small Grants Program was to draft a grants management program to be submitted to USAID for approval. The Small Grants Program Management Plan (see Appendix G3) describes the procedures used by the Program to manage and implement the grants program. It was prepared by Zdrav*Reform* staff and approved by AID/Washington Contracts Office in March 1994.

Following the development of the procedures for running the Grants Program, the ZRP team began developing the standard documents necessary under the program. The documents were translated and approved by USAID in May 1994. They included:

- Standard Grants Announcement,
- Standard Grant Application Format,
- Instructions for Writing Grant Application,
- Standard Criteria for Evaluating Applications,
- Standard Grant Agreement

See Appendix G4 for copies of these documents.

Grants to Governmental Organizations

USAID policy prohibits the procurement of goods and services from government-owned entities except as the Contracting Officer may otherwise agree in writing. However, since most of the sources of services in Russia as they relate to the work of Abt on the Zdrav*Reform* Program are governmental organizations (for example, local health care committees, insurance funds, and regional hospitals and polyclinics), a waiver was signed by Jim Norris on January 23, 1995 and by Barbara Brocker on June 14, 1995 to allow Abt to enter into contracts with Russian governmental organizations. It followed that a large number of Russia grants were given to governmental organizations.

Fast Track Grants

Beginning in June 1994, the ZRP team with USAID determined the topics for the first round of grants:

- The development of innovative contracts between hospital-polyclinic organizations and payers of health care (including employers, TFMHI and the State) that pays the service provider on a basis that offers

economic incentives for improved quality of care and/or more cost-effective care; for example capitation or per diagnosis payments in which providers receive a fixed fee for a defined list of services.

- Innovative programs to improve the quality of care as measured in either clinical outcomes and/or improved patient satisfaction; and

- Innovative programs to improve the efficiency of hospital care, reduce the length of hospital stays for selected diagnoses or to shift treatment to outpatient polyclinics.

In August 1994, the Grants Manager visited ZRP's Siberian Geographical Focus Areas (GFA's) to discuss with local health officials their proposals for activities in their oblast that would be funded through the small grants program. Zdrav*Reform* and USAID staff in Moscow and Washington agreed that one grant should be awarded to each oblast in a non-competitive manner as a means to begin the rapid implementation of Zdrav*Reform* activities in the oblasts. Official approval was given to award sole source grants to the five organizations described below on October 21, 1994 in a letter written by Nancy Pielemeier and signed by Katie McDonald and Catherine Mallay. Four of the sole source grants were awarded from December 1994 through February 1995:

1. ASOPO Zhizn Insurance Company, Novosibirsk: Restructuring polyclinics to form free-standing primary care units, $50,000.

2. Novoaltaisk Hospital, Barnaul: Reorganizing in-patient care to create three distinct levels of care, $42,000.

3. Kemerovo Institute of Social and Economic Problems of Health Care, Kemerovo: Developing Medical Economic Standards (MES) for out-patient care, $58,400.

4. Altai Krai Health Care Committee, Altai Krai: Development of a private family practice physician office, $71,200.

Due to time constraints, the fifth sole source grant to the Tomsk Health Care Committee for $45,400 was awarded in May 1995. It was given to develop new, performance-based methods of paying for in-patient care.

First Competition

Following these early awards to projects in the intensive demonstration sites, from September - November, 1994, the Zdrav*Reform* Program's Russia Regional Office circulated an open request for proposals for small grant awards. English and Russian versions of the request for proposals were distributed widely within Siberian oblasts where the Zdrav*Reform* Program was providing extensive technical assistance and to counterpart organizations within the Russian Ministry of Health, including the Federal Fund for Mandatory Health Insurance and the Public Health Institute. In addition, the request for proposals was also distributed to several grant making organizations in Moscow (Eurasia and McArthur Foundation) and to the representative offices of other USAID funded projects (World Learning and American International Health Alliance).

Twenty-two proposals were received by the deadline of November 30, 1994. After a review of these proposals by Zdrav*Reform* staff, including the Acting Country Director, the Grants Officer, and the Technical Advisors, ZRP recommended funding for three of the proposals with a total value of $189,889. These three projects are summarized below.

1. Tula-Albany Health Care Insurance Company, Tula: Establishing a non-for-profit organization that can provide an integrated set of in-patient and out-patient services and provide insurance to cover the costs of these services, $99,900.

2. Nizhny Novgorod Alcoholism Treatment Program - “Center of Twelve Steps”, Nizhny Novgorod: Establishing a new alcoholism treatment center based on the "Disease Model Concept" and the Alcoholics Anonymous model, $32,312.

3. LangMedService Insurance Company, Langepas: Developing the infrastructure to allow the LukOil Insurance company to offer both mandatory health insurance and to underwrite and market private voluntary health insurance, $57,677.

Increased Funding

In early 1995, although overall funding for the Zdrav*Reform* Program was decreased, funding for the Small Grants Program was increased to $3 million, with individual awards increased up to $100,000.

Quality Improvement

The next request for proposals was issued in March and April 1995 for projects to improve the efficiency and quality of hospital and polyclinic services. The announcement was similarly distributed around Siberia, Western Russia, other grant making organizations, and to all organizations who submitted a proposal in the first competition.

Recent studies suggested that a disproportionate share of Russia's health resources was allocated to the hospital sector. Within the hospital sector, the delivery of health services was not as cost-effective as some managers would have wanted. There was an excess bed capacity that attracted too many referral patients to hospitals, and lead to high costs. Once hospitalized, the average length of stay was excessive. Furthermore hospital admission rates were high because polyclinics did not have adequate professional and technological expertise to complete several procedures on an outpatient basis. These several factors contributed to an inappropriate use of scare resources. The Small Grant Program’s first competition was held for organizations willing to design and promote the development of new payment methods and new resource management processes that could help improve this situation.

Twenty-five proposals were received by the deadline of April 28, 1995. After a review of these proposals by Zdrav*Reform* staff and representatives of the Federal Fund, ZRP recommended funding nine of the proposals with a total value of $350,000. These nine projects are summarized below.

1. Municipal Hospital Number 2, Vladivostok: Reforming Hospital Accounting and Financial Planning Systems, $50,000. (AIHA partner).

2. Territorial Fund of Mandatory Health Insurance, Sverdlovsk Oblast: Reducing Post-Operative Length of Stay and Improving Information Systems, $50,000.

3. Stoic-Med, Ltd. Insurance Company, Tomsk: Privatizing OB/GYN hospital and introducing fee-for-service, $50,000.

4. Novosibirsk Emergency Care Clinic #1: Developing Multi-Level In-patient care and shifting care to the out-patient sector, $25,000.

5. Stavropol Krai Clinical Hospital, Stavropol: Organizing Cost-Effective In-patient Health Care, $50,000 (AIHA partner).

6. MedExpress Insurance Joint Stock Company, St. Petersburg: Organizing private, general practitioners, $34,000.

7. Sokolov Hospital, CMID - 122, St. Petersburg: Reducing Hospital Length of Stay, Shifting Care to the Out-Patient Sector and Improving Quality of In-patient care, $50,000.

8. Central Municipal Hospital, Dubna: Reducing Hospital Length of Stay for Patients with Acute Myocardial Infarction, $25,000.

9. Ray of Hope Charitable Association, Moscow: Demonstrating the Cost Effectiveness of Selected Public Health Screening and Preventive Services, $25,000.

Final agreements were signed with all but two of the above organizations. Due to an inability to reach agreement between parties, final contracts were not signed with either Stoic-Med or the Novosibirsk Emergency Care Clinic.

Healthy Communities

In May 1995, the Small Grants Program circulated a request for proposals for a grants round entitled, "Healthy Communities." This announcement was developed with the help of Yulia Abrosimova from the Russian Ministry of Health's research institute MedSocEconInform. Ms. Abrosimova had been introducing the idea of Healthy Cities to Russian cities and her office had been translating and distributing WHO Healthy Cities material to interested organizations. Ms. Abrosimova and David Boyd, the Grants Manager, attended the meeting of the Union of Russian Cities in May and announced the grants competition at this conference. In addition, the announcement was sent to federal and local organizations, such as the Federal Fund for Mandatory Health Insurance, the Public Health Institute, regional health care committees, territorial funds, and other organizations who requested information. Other grant-making and/or USAID-funded organizations in Moscow, such as World Learning and the MacArthur Foundation, were notified of the competition as well.

The intent of this particular round of grants was to encourage the development of broad-based health promotion programs in cities which would be modeled on the WHO Healthy Cities project. Grantees were asked to choose one important health issue in their community and find creative ways to address and remedy the problem while involving a wide portion of the community.

Twenty-seven proposals were received by the deadline of July 7, 1995. After a review of these proposals by Zdrav*Reform* staff, representatives of MedSocEconInform, and WHO, ZRP recommended funding three of the proposals with a total value of $300,000. These three projects are summarized below.

1. Izhevsk Department of Health Care: improving the status of maternal and child health, $99,900.

2. Kostroma Department of Health Care: improving the status of children's and women's health by means of decreasing the number of abortions and to prevent unwanted pregnancies, $99,900*.

3. Lipetsk Department of Health Care: developing a broad-based immunization program, $99,900*.

* Both Kostroma's and Lipetsk's grants were subsequently reduced in funding due to their refusal to do sufficiently broad-based programs.

In early June 1995, David Boyd, for personal reasons, decided to return to the United States, and thus give up his position as grants manager. Mr. Boyd trained the new grants manager, Karen Martin, on all existing procedures, and the two of them worked together in running both the Healthy Communities competition and the following *Health Sector Leadership* competition.

Health Sector Leadership Development

Beginning on June 30, 1995, the Zdrav*Reform* Program's Moscow office circulated a request for proposals for a grants round entitled, "Health Sector Leadership Development." The announcement was widely distributed to over seventy organizations and individuals throughout Russia, including both federal and local government institutions, medical academies and institutes, hospitals and polyclinics, local health NGOs, and international NGOs and grant-making organizations. Zdrav*Reform* Program's Novosibirsk office played an important role in disseminating the information in Siberia. The announcement was also distributed by e-mail (NIS Health Network). The announcement was developed by Jim Rice, director of the Moscow office, with the help of Karen Martin. In order to facilitate the proposal writing process, an open meeting was held on July 11, 1995, in Moscow. Jim Rice, David Boyd, and Karen Martin led the meeting. Approximately twenty-five people attended the meeting and asked general questions about writing proposals. It was made clear that attendance at this meeting would have no influence on the grant selection committee's funding decisions.

The goal of this grants program was to fund organizations which were promoting leadership in the healthcare sector in a variety of ways, primarily through creation of professional associations, publication of new journals and newsletters, and development of management training programs. Russian health sector reform cannot be sustained without experienced, innovative and effective managers. Management development is therefore an essential prerequisite to the long-term success of reforms and thus became an important component in the ZRP Grants Program.

The deadline for receipt of proposals was July 21, 1995. The Zdrav*Reform* Program's Moscow office received 56 proposals. After a review of these proposals by Zdrav*Reform* staff, representatives of World Learning, the Eurasia Foundation, the Education Development Center, USAID, and a Russian medical doctor from the Spaso-Perovskogo Hospital, ZRP recommended funding sixteen of the proposals with a total value of $845,000. These projects are summarized below.

1. Saint Petersburg Medical Academy: Developing innovative training programs for Russian managers in the areas of financial planning and management, human health care management, new methods of medical insurance, and medical market research, $50,000.

2. Regional Fund of Compulsory Medical Insurance, Rostov Oblast: Training health care leaders to better manage and improve the quality of the health care system in a market economy, $55,000.

3. Association of Don Physicians, Rostov Oblast: Publishing the monthly "Don Physicians Newsletter," $50,000.

4. Regional Educational-Methodological Center of the Far Eastern Medical Association, Khabarovsk: Providing continuing education courses in the field of health sector management and insurance management in the Far East, $65,000.

5. Russian Charitable Fund "No to Alcoholism and Drug Addiction", Moscow: Developing a training course for health care leaders, managers of treatment and rehabilitation programs, and local health care administrators in adapting American methods of treatment and prevention of alcohol and drug addiction to the Russian experience, $25,000.

6. Central Clinical Hospital the President's Administrative Department Medical Center, Moscow: Pursuing a "Quality Indicator Project" with the goal of improving health care delivery, $45,000.

7. Leadership Training Center Under "MedSocEconInform" Public Health Institute, Moscow: Creating a training program for health care professionals, $54,990.

8. Academy of National Economy Under the Government of Russian Federation, Business Management Center, Institute for Senior Executives, Moscow: Establishing a management training program for chief physicians of medical establishments, $70,000.

9. Siberian Fund of Management Development, Kemerovo: Establishing a continuing education and certificate program in the area of health maintenance and insurance, $65,000.

10. Novosibirsk State Academy of Economy and Management: Developing a new management training program for health care professionals, $65,000.
11. Saint-Petersburg Association of General Medical Practice: Joining the efforts of GPs and Specialists in the development and improvement of the quality of primary care and to organize it on the principles of general practice, $35,000

12. AESOP Center, Moscow: Establishing the Sexual Health Coalition and train NGO leaders in the area of sexual health, $25,000.

13. All-Russia Nurses Association, St. Petersburg: Develop a strengthened and sustainable ARNA so that it will advocate for the needs of practicing nurses, speak on behalf of nurses on issues of health care policy, serve as clearinghouse of information on nursing, $75,000.

14. Moscow Association of Health Insurance Organizations: Publishing articles on timely subjects in the journal *Health Insurance*, the newspaper *Medical Courier*, and in general interest papers such as *Izvestia* and *Trud,* $60,000.

15. Foundation for the Development of Health Care Management Training Program, Moscow: Establishing an organization to develop training programs in modern health care management methods, publish educational materials, and facilitate communication between various health care management programs, $80,000.

16. Russian Academy of Medical Sciences, Semashko Institute: Publishing five special supplements on current health issues in the journal, *The Problems of Social Hygiene and the History of Medicine,* $37,550.

A final contract was not signed with the Saint-Petersburg Association of General Medical Practice. When the Zdrav*Reform* team found out that the organization that had turned in the proposal under this competition was a newly formed organization that was working independently of the original Association of General Practitioners which had been working successfully for several years both within Russia and with the international community, Zdrav*Reform* concluded discussions with the organization that had submitted the proposal.

Territorial Fund Payment Reform

In early November 1995, the Zdrav*Reform* Program's Moscow office circulated a request for proposals for a grants round entitled, "Territorial Fund Payment Reform" to develop working pilot projects in which Russian and American health care leaders demonstrate the value of reforms for a) quality of care, b) new payment methods for hospitals, polyclinics, and physicians that have incentives for consumer choice and improved provider performance; and c) new health management information systems, services delivery, and/or health care financing.

In early December 1995, Karen Martin left her position with Abt Associates to take a new position with the Soros Foundation. Ms. Martin completed all preparations for the last competition, trained the new grants manager, Ellen Bobronnikov, and a new associate, Yulia Solovieva, on all existing procedures.

The deadline for receipt of proposals was December 15, 1995. Zdrav*Reform* Program's Moscow office received 7 proposals. After a review of these proposals by Zdrav*Reform* staff and representatives of the World Bank and USAID, ZRP recommended funding four of the proposals with a total value of $265,000. These projects are summarized below.

1. Kaluga Mandatory Health Insurance Fund: Developing working pilot projects in which Russian and American health care leaders demonstrate the value of reforms for a) quality of care, b) new payment methods; and c) new health management information systems, services delivery, and/or health care financing, $95,000.

2. Tver Oblast Mandatory Health Insurance Fund: Developing working pilot projects in which Russian and American health care leaders demonstrate the value of reforms for a) quality of care, b) new payment methods; and c) new health management information systems, services delivery, and/or health care financing, $95,000.

3. Cherapanova Regional Hospital (Novosibirsk TF): Restructuring a rural health care delivery and financial system, $50,000.

4. The Tula Territorial Fund of Mandatory Health Insurance: Developing a system of reform in the methods of payment to health care providers, $25,000.

Monitoring Grants

By early 1996, grant agreements were negotiated for thirty-eight organizations with awards totaling over two million dollars. Many of these organizations had no experience working with Western organizations and had never dealt with contracts before. However, because the Grants Team was limited to Ms. Martin, the Grants Manager (with assistance from the technical staff as necessary) until December 1995, and she had to spend the majority of time running new competitions and negotiating new agreements, formal monitoring of the grants was not feasible. When grantees called with problems, the Grants Manager helped them to address these issues. Additionally, when obvious limitations existed in the grantee's ability to formulate a sound scope of work or to perform their work, technical advisors, chosen from the ZRP technical staff, assisted them in this effort. However, there were not enough resources to monitor them pro-actively until after all of the grants were signed.

By early 1996, although resources were still low, to help ensure smooth progress of work on these new grants and adherence to contracts, Ms. Bobronnikov, the new Grants Manager and Ms. Solovieva, her associate began to monitor the projects as closely as possible. On a quarterly basis, grant recipients were required to send detailed technical and financial reports. The technical reports discussed their grant activities of the previous quarter and their plans for the next quarter. These allowed potential setbacks to be identified in a timely manner. Grantees were also encouraged

to send monthly status reports. The financial reports demonstrated how both grant funds and matching funds were spent up to that point, and provided predictions as to how funds would be spent in the future. Based on these reports, money was wired to the grantees on an as-needed basis, typically about once a quarter. In addition to these reports, site visits were conducted when feasible, and regular communications were conducted with grantees via letters, telephone, and electronic mail.

After all grants were negotiated and signed, Ms. Bobronnikov, started a schedule of working approximately half time in the field and half time from the United States. During her periods in Moscow, the grants manager worked as closely with the grantees as possible, dealing with all major issues that occurred, and enacting systems (i.e. monitoring, report collection, money transfers, and preparation of study tours) so that the Grants Associate would be able to continue working effectively with the grants in the Grant Manager's absence. While in the United States, Ms. Bobronnikov continued to communicate daily with the Ms. Solovieva by telephone and electronic mail. In this way, the monitoring process continued uninterrupted throughout the life of the grants.

Although this monitoring system allowed the Grants Team (Grants Manager, Grants Associate, and Technical Staff assigned to grants) to identify the majority of problems as they arose so that they could be dealt with before they escalated to a higher level, the Grants Team did not have the resources to devote the time necessary to work effectively with all of the grants which were active at a given time, most of which had never worked with Western organizations or formal contracts in the past, and thus needed more attention. This problem was aggravated even further by the fact that the majority of the grantees started their work in the last year of the contract, and were forced to work extremely diligently in order to finish their ambitious projects. As can be seen in Table 1 below, by the end of 1995, only 5 grants had completed their work, leaving 33 to complete in 1996, 21 of which had only started their work on the grants between November 1995 and February 1996. The majority of grantees had less than one year to complete their grants (the average duration of a grant was less than 10 months).

Table 1: Grant Start and Finish Dates

Start Dates	# of Grants	Finish Dates	# of Grants
Dec 1994- July 1995	12	July - Dec 1995	4
Aug - Oct 1995	5	Jan - April 1996	4
Nov 1995 - Feb 1996	21	May - Sept 1996	12
		Oct 1996	18

The final grants were to be completed by October 31, 1996. At the end of each grant, grantees were required to turn in final technical and financial reports and all final grant deliverables. However, because of a family emergency, the Grants Manager had to return to the United States in late October, and was not able to return to collect final documents until February 1997. As of October, 141 out of 187 delivs and about half of final reports had been collected.

Dissemination

In addition to monitoring the grants, in order to help promote reform *throughout* the country, the Grants Team encouraged dissemination as feasible. Although there were limited funds for dissemination, the Grants Team discussed the successes of the grants and the new concepts being experimented with through the grants with other grantees, local NGO's, and people within the health administrations. In addition, grantees were encouraged to travel locally in order to see the work performed under related grants, to circulate papers describing work done under the grants, and to hold conferences on grant related topics. This increased the potential for the successes to be known and replicated throughout the region. Replication would help assure that the program results would be sustained. In addition to disseminating the *types of work* being undertaken and the new

ideas involved, the Grants Team also felt that it was crucial to disseminate the *final results* of this work. Many of the final products of the grants will be put on a CD ROM which will be made publicly available. Additionally, in November 1996 the Zdrav*Reform* Team showcased and distributed their final products in a conference entitled "All-Russia Conference for Health Care Reform in Russia: The Experience with Russian-American Cooperation," organized by Avanta Advanced Studies Institute for Health Care and Social Insurance Managers. Healthcare leaders from around Russia were invited to this conference and had the opportunity to learn about the reforms enacted under Zdrav*Reform*, meet other key players in healthcare reform, and receive copies of articles, manuals, and software developed under the Zdrav*Reform* Program.

C. Procedures ZdravReform Followed in Running the Small Grants Program

The procedures that the Zdrav*Reform* Grants Team determined were important in running an effective Small Grants Program in health sector reform in Russia are described below. Each of these factors required advance planning, discussion and mutual agreement with USAID and often with host country health reform players.

Setting Objectives:

One of the first steps necessary in starting the grants program was to carefully define the objectives of the program. The Zdrav*Reform* Team decided that these objectives should share those of the overall program while also balancing out the program by adding some complementary objectives. They needed to take advantage of existing host country skills and resources and to be focused on meaningful, systemic change that could lead to a significant reform of the system. It was also important that while the programs should effect significant change, they should not be so big that they would be too difficult to manage. The Grants Team felt that it was important to allow for early successes and visible results in order to achieve a high probability of sustainability.

The early objectives of the ZRP's Small Grants Program were to provide funding for NIS-based institutions and individuals to design and implement innovative, experimental pilot projects that would have clear policy implications and that would demonstrate to NIS-based health personnel and AID how to improve or increase the *financing*, *quality*, *efficiency*, *distribution* and *management* of health services in the NIS.

As the program progressed the objectives were further refined to include:

- Establishment Of Free-Standing General Practices;
- Development Of New Payment Methods;
- Dissemination and Leadership Development;
- Healthy Lifestyle Promotion; and
- Efficiency Improvement Of In-Patient Care.

Refer to Appendix G1 for a description of the grants under each of these topics.

Finding Suitable Grantees:

Once the objectives of the programs were determined, it was necessary to find local organizations who would run them. Zdrav*Reform* and USAID staff in Moscow and Washington agreed in order to being the rapid implementation of Zdrav*Reform* activities in the oblasts, early grants could be awarded to organizations in each of the GFAs in a non-competitive manner.

Future grants were awarded based on competitions. Although competitions require more time and resources, they introduce a wider selection of

organizations, including some smaller ones that otherwise may not otherwise be recognized. In order to solicit as many serious bids as possible, the Grants Team advertised the competition as widely as possible and through industry sources. Zdrav*Reform*'s competitions were advertised through federal and local government institutions, medical academies and institutes, hospitals and polyclinics, local health NGOs, and international NGOs and grant-making organizations. See individual descriptions of competitions under Section II for specifics by competition.

Competitions were advertised from one to three months in advance with standard grant application format and instructions sent out to all interested parties. (See Appendix G4 for grant announcement and standard grant application format and instructions). Because proposal writing was new to many of the grantees, the Grants Team was always available to answer questions that arose. In one instance, for the Healthy Communities competition, because the concept of a "Healthy Community" was new to the Russian people, the Grants Team invited interested applicants to a workshop in St. Petersburg to help generate interest in the program and its agenda and to assist those interested in developing concepts for grant activities and in preparing grant applications. As expected, this time invested up front for the competitions yielded significant benefits. Not only did it help increase the quality of responses and make it more clear who is most capable of doing the work, but by helping applicants to put together a proposal that was well written and thought out, a significant part of their work was already accomplished. The proposal writing process helped applicants to focus on the objectives, and even though there were only a limited number of winners, it may have lead some of the organizations who did not win to find other sources of funding to run the programs.

Judging Proposals:

Once all of the applicants were received, it was necessary to create a "Grant Selection Committee" to choose the best proposals. The committees for each of the competitions were made as unbiased as possible by including both local and foreign members, from various interested organizations. All proposals were translated for the foreign teammembers for maximum understanding. For the smaller competitions, all teammembers read each of the proposals, and for larger competitions, the committees were broken into teams, each reading a fraction of the total number of proposals and sharing their thoughts about each proposal to the rest of the group. Discussions were very detailed, allowing each member to express his/her opinions. Winning proposals were based upon the following criteria: 1) an adequate record of performance with similar scaled projects; 2) the integrity and management competence with respect to planning and implementing programs; and 3) the ability to complete the grant program, given all existing and prospective commitments. (See Appendix G5 for a descriptions of the selection process and of the selection criteria for one of the competitions). The committee not only decided upon the winning proposals, but they also made determinations as to how much to award each organization. Each funded element of the grant activity presented in the budget section of the application was reviewed to determine if it was reasonable and allowable according to applicable cost principles. All selected winning proposals were sent to USAID for approval (see Appendix G6 for steps on establishing a new grant).

Finally, in notifying the "winners" and the "losers," the Grants Team felt that it was important to celebrate the success of the winners, but it was just as important to encourage those not selected to continue their effort at reform.

Developing the Grant Agreement:

After notifications of award were given to the grantees for each of the competitions, the next step was to compose the grant agreement, the contract between Abt Associates and the grantee that defined the specific activities that would be carried out with the grant funds. This contract clearly defined expectations and accountabilities of all parties to the grant project. All standard agreements included clauses regarding the schedule of

reports, the grant budget, and general provisions. A detailed grant agreement implied a well thought out program understood and agreed by both parties. The standard format for all grant agreements was approved by USAID in May 1994 (see Appendix G4).

Grantees were instructed to read the core agreements very carefully and to compose the grant program description (referred to as Attachment A in the agreement) based on their proposal over a specified time period. Their project description as written in the proposal was typically further clarified and condensed into a clear, step-by-step project schedule. The following sections were included in Attachment A:

- **Background** - a general description of the organization and of the general situation that led them to pursue this project;

- **Grant Objectives -** focused objectives of what would be accomplished under the grant;

- **Workplan and Schedule** - a month-by-month detailed description of activities and who would carry them out;

- **Indicators for Monitoring Grant Program Implementation** - measurable indicators that would help determine whether grantees were making meaningful progress toward their goals (i.e. hospital stay reduced by 10%, increase in membership of association, increase in patient satisfaction, etc.);

- **Expected Outcomes of Grant Program Implementation** - specific outcomes that would come out of the grant (i.e. creation of free standing general practice, development of system for decision making based on quality indicators, creation of a new system of training health care managers, etc.);

- **Documents to be Produced Under Grant Program** - Final documents to be turned in by the end of the grant (i.e., reports, software, manuals, legal documents, etc.); and

- **Grant Budget**. - A detailed line item budget by program category, including salaries (and taxes), consultants, travel, commodities, other direct costs and indirect describing how grant funds and matching funds of at least 25% of the grant will be spent. The budgets were supposed to be very detailed. Every sum was to be explicitly explained. For example, if money was going for salaries, the sum should have be broken down by position, the number of people working, the amount of time working, and their daily salary. Travel was supposed to be broken down into tickets, visa expenses, per diem, etc. Budgets for early grants were typically less detailed, and over time the requirements became more stringent.

Since the grantees typically did not have experience writing such detailed contracts, workplans, or budgets, it was often necessary to help them formulate the workplan and budget within the agreement, but it was also important to keep them as involved as possible in the process, so that they would feel an ownership of the plan and would be able to implement it. This process of composing Attachment A was often reiterative, where the grantees would send a first version of Attachment A to the Grant Manager, and she, with other members of her team, would make suggestions and try to further clarify some of the sections, send it back to the grantee for further work, and the cycle would continue until the Grant Manager determined that the agreement was complete. At this point, the Grants Manager first sent the entire agreement over to USAID for approval, held a signing ceremony (if feasible) to sign the contract together with the grantee in the office (if it was not feasible for the grantee to come in to the office, documents were first signed by the Grants Manager, then faxed to the Grantee, signed by the Grantee, and faxed back to the Grants Manager, with originals copies later sent to each party), and finally sent the Grant Agreement to Abt Bethesda for approval.

In addition to finalizing the agreement, there were 2 steps that needed to occur before the grant could officially begin: a *pre-award audit* needed to be performed to ensure that each organization had acceptable management and personnel procedures in order to properly administer the grant (see Appendix G7), and a separate*, non-interest bearing bank account needed to be opened* to be used for grant funds only. As soon as the new accounts were opened, Grantees were requested to provide the Grants Manager with the account information for money transfers. After the contract and the pre-award audit were complete, a document with reporting and other administrative requirements was given to each of the grantees (see Appendix G8).

Work on the Grant:

Transferring Funds and Report Requirements

Since most of the organizations which received grants had little or no available funds of their own to start working on their projects, the first step in beginning a grant was to transfer money to their accounts so that they could begin work in earnest. Even before the grant agreements were signed, the Grants Team requested to the Grantees that they send money requests, determining how much money would needed for the first quarter (to be based on the budget agreed to in the contract) and providing a budget showing how the money would be spent. In this way the Grants Team was able to estimate in advance how much money would be necessary to have on hand, so that it could be transferred as soon as possible after approval. Unfortunately, often incorrect banking information led to holdup on transfers and delays in work.

Although the Grants Team felt that it was important for grantees to know that someone was carefully monitoring their progress, congratulating them when things went going well, and willing to help them when problems arose, resources were exceedingly low given the large number of grantees, and regular communication with all of the grantees was not feasible. The Grants Manager set up a reporting schedule whereby Grantees would report monthly with a *brief report* on their program's activities for the past month and intended activities for the next month, including any questions or problems they needed assistance with, and report quarterly with a more detailed *technical report* describing progress of each stage of work, problems and successes, and changes from the original scope of work, and with *financial reports* listing how much money (both grant funds and matching funds) had been spent to date, how it had been spent, how much money was needed for the following quarter and how it would be spent.
These reports helped the Grants Team stay informed so that they could provide help when they thought it was necessary to help avoid potential problems and to congratulate them at high points, and they also helped the grantees to monitor their own progress and how they expended their budgets.

Grantee Technical Support

In addition to providing grantees with financial support, it was also necessary to provide them with technical support to aid them in areas that they have had little or no prior experience. This was accomplished in various ways: providing them with *technical assistance* on site; giving them the opportunity for *local or foreign travel* to see new concepts in action; teaming them up with outside *partners* such as universities or foreign organizations who had a mutual interest in keeping up the relationship beyond the horizon of the grant; and supplying them with guides, manuals, software, or other documentation. Technical assistance also came from other grantees and host country experts.
Under many of the grants, work was performed in areas in which the grantees had little or no previous experience. For these projects especially, it was critical to provide *assistance from ZdravReform technical staff.* One technical advisors was assigned to each of the grantees from the ZRP technical staff. The level of assistance ranged, however, from working very closely with the grantees throughout the life of the grant to being available only when called upon. For grants in the GFA's whose work closely related to the work done in the remainder of the program, technical advisors typically worked closely with the organizations from the beginning, in helping to prepare the Grant Agreement, to the end, working with them at key points throughout the life of the grant. In addition to Zdrav*Reform* staff providing technical assistance, some of the leadership development grants were involved in partnerships with American Universities.

Local and foreign travel was encouraged when it provided the opportunity to learn from related projects or to learn about related concepts. Seeing a concept in action is often the most effective way to learn how to integrate that new concept into actual work. Trips locally were strongly recommended, and those overseas were only recommended when there was nothing comparable locally. Much preparation was needed for foreign trips (see Appendix G9 for the procedural guide and checklist for organizing study tours given to all grantees involved in foreign travel). The logistical procedures for organizing study tours were dictated by USAID's Handbook 10, the policy manual intended for USAID-funded training projects. In addition to helping grantees with all of the planning necessary to prepare an effective study tour and with the logistics, including obtaining visas and insurance, Abt Associates sometimes sponsored the tours in the US, preparing all of the meetings, giving talks themselves, and escorting the grantees to the sites. See Appendix G10 for a list of all grants involved in study tours.

Sometimes, the most effective *support can come from fellow grantees* experiencing similar challenges. Grantees were given descriptions of all of the grants being supported by the program and contact names and numbers so they can easily consult each other. Since many of the hurdles faced by the grantees were similar from region to region, communications and visits

provide the parties an opportunity to discuss their progress with their peers, and learn from each other's successes. In one instance, the Grants Team helped to organize a workshop for the three Healthy Community Grants. This workshop was a big success. Although only one of the three organizations with Healthy Community Grants was present, other organizations from all over Russia participated to learn more about forming healthy communities. As a result of this workshop, many other cities are seriously thinking about beginning their own "healthy communities."

D. Ideal Grants and Obstacles to Successful Grants Programs

Based upon the experiences in the Russian Small Grants Program, a number of factors have been recognized that should be focused upon and others that should be minimized as other programs seek to design, implement and operate grants programs that can be valuable instruments for sustainable reform.

The characteristics of a successful grantee include the following:

Technical Competence	Prior experience in targeted theme area Depth of experience to do the work Commitment to seek innovation and a new path Breadth of involvement from interdisciplinary team
Credible/ Strategic Position	Geographic or organizational preeminence Good reputation of key people Prior reputation as innovator
Capacity for Grant Administration	Stable banking arrangements Transparent accounting policies/systems Commitment for timely reporting
Sustainability	Willingness to share results with others
Prospects	Advance plan to accomplish sharing of results Commitment to sustain successful projects

The following obstacles should be avoided. Managing the grants program to address these in a creative and professional manner is essential to optimize the grant program's contributions. There are practical considerations on how to convert these risks of failure into positive features for success.

It is crucial to have ***adequate solicitations to find appropriate applicants***. After the program priorities have has been defined, the first step in a successful grants program is to find grantee applicants that possess as many of the characteristics listed above as possible. The availability of a grant applicant pool can "make or break" the successful grants program. If a competition is poorly advertised, chances are one will not find the groups that are most interested and able to carry out innovative reform. If one only works with the groups that are most well connected or have had other opportunities, the program may miss access to fresh approaches.

Portfolios should ***not be too focused on foreign priorities***. For these projects to be successful and sustainable, they should focus on the local priorities, with only modest advice given from the foreign donor organization.

A portfolio ***should not be too narrowly focused***. In order to effect significant change, the portfolio should be as global as possible while remaining manageable. Each individual project needs to have a significant outcome, and it is best to have several groups working on the same topic areas. This allows independent perspectives and cooperation within an area. Finally, it is best to cover as many corresponding areas as financially possible and manageable, so that prospects for reform can be made across an entire spectrum.

On the other hand, a portfolio ***should not be too large to manage***. In trying to effect significant change, one should not be overly ambitious. This can

lead to people thinking change is impossible to effect. Programs need to be significant while manageable.

The ***grant agreement needs to be sufficiently detailed*** so that the grantee has a structured plan for its work, and the donor can assure appropriate accountability. Without such a plan, there is a greater risk that time will be wasted on non-essential goals and activities.

It is important not to be too ***paternalistic*** with grantees. These are *their* projects, and it is important for them to experience full ownership of the process and results. Grantees are more likely to learn sustainable lessons from their own mistakes and success. Technical assistance from the grant program and other grantees can, of course, be available to support these processes.

On the other hand, it is ***crucial to closely monitor and support the grantees***. There should be regular reporting requirements to ensure that the grantee stays on track, and if they are having trouble, they can be helped when there is still time to enhance their performance.

There should also be the ***opportunity for mid-course corrections***. If in working on the original project, the grantees find that it makes more sense to redefine the workplan and make some changes, this needs to be allowable.

Finally, it is important to plan early for a ***strong dissemination plan***. This increases the potential for the successes to be known and replicated throughout the region. Replication helps assure that the program results are sustained.

E. Conclusions

The Small Grants Program has been an effective complement to the technical assistance program in that it has allowed the concepts introduced under the Zdrav*Reform* Program to spread to a much larger audience than otherwise possible. Additionally, the grants have helped to broaden the program by funding educational initiatives which help ensure that these methods and tools get passed on to new and existing managers in healthcare and by funding dissemination efforts.

Contractually, although many of the grant recipients were fledgling organizations without significant experience working with Western organizations or even with contracts, the program has been a great success. The following progress was made:

- ⇒ 97% of final grant products have been collected;
- ⇒ *100%* of final technical reports have been submitted;
- ⇒ 97% of final financial reports have been received, with only one grant who has not fully demonstrated how their funds have been spent; and
- ⇒ 100% grants have met their financial obligations, including returning their unused funds.

In addition to being a contractual success, the interest in Zdrav*Reform*'s Small Grants Program is clearly high. During the Dissemination Conference in November 1996, a great deal of interest was shown in all aspects of the grants program, from the administrative workings of awarding grants to the types of projects performed under the existing grants. Apart from all of the information about the grants program distributed at the conference, an additional forty requests for further information was taken and later sent out.

As a final statement of its success, at least three fourths of all grants are pursuing follow-on work to grant related activities. These activities range

from the running of private general practices, to the use of MIS for cost accounting and managing financial transactions within hospitals and polyclinics, to the existence of innovative training programs for Russian healthcare managers, to the increasing number of cities pursuing the development of "healthy communities."

Zdrav*Reform*
Russia

Technical Appendices to Final Report to USAID Moscow

TECHNICAL APPENDICES

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APPENDIX 1

LIST OF ACRONYMS USED IN THIS REPORT

Appendix 1: List of Acronyms Used in This Report

AIHA	American Industrial Hygiene Association
AKCD	Altai Krai Cardiology Department
ALOS	Average Length of Stay
ARNA	All Russia Nurses' Association
AUPHA	Association of University Programs in Health Administration
AVANTA	Advanced Studies of Health Care and Insurance Managers
CQD	Continuous Quality Development
CQI	Continuous Quality Improvement
DRG	Diagnostic Related Groups
FGP	Freestanding General Practice
GFA	Geographical Focus Area
GP	General Practice
HCP	Healthy Cities Program
HIA	Health Insurance Associations
HMO	Health Maintenance Organizations
JCI	Joint Commission International
KPI	Kaiser Permanente International
LAN	Local Area Network
LOS	Length of Stay
MES	Medical Economic Standards
MI	Myocardial Infarction
NHS	National Health Service
NIS	New Independent States
OECD	Organization for Economic Cooperation and Development
OSC	Overnight Surgery Center
PC	Personal Computer
QA	Quality Assurance
QI	Quality Improvement
RF	Russian Federation
RPM	Rational Pharmacy Management
SPHA	Siberian Public Health Association
TF	Territorial Fund
TFMHI	Territorial Fund Mandatory Health Insurance
USAID	United States Agency for International Development
ZRP	Zdrav*Reform* Program

APPENDIX 2

INDICATORS FOR SIBERIAN PILOT SITES

FUNDING AND MANAGEMENT OF RESOURCES
Zdrav*Reform* PROJECT IMPLEMENTATION ASSESSMENT
CRITERIA
FOR ALTAI KRAI

INDICATORS	1. Share of actual allocations to public health facilities, provided through contracts with the funding source (Health Committees and insurance companies), percentage	2. Outpatient care expenditures as a percentage in total health expenditures in pilot sites covered by **Zdrav***Reform*		3. Share of primary care physicians in the total number of physicians in pilot sites, percentage		4. Referral rate in pilot sites, percentage	5. Number of admissions per 1,000 of the population	6. Number of calls to emergency care stations per 1,000 of the population	7. Scope of disease prevention measures, percentage of groups of population: - pregnant women - pre-school children - schoolchildren			8. Hospital bed capacity in the pilot sites per 10,000 of the population	9. Number of operational day care centers in the pilot sites: - hospitals - outpatient surgeries - home care units	
1994														
	22.4	sites 1,2,3	23.2	all sites	33.8	28.5	218.6	372.2	97.3	99.7	98.6	83.9	hospitals	6
		sites 4,5,6	42.7	sites 1,2,3	42.2								outpatient surgeries	4
				sites 4,5,6	25.1								home care units	1
1st Half 1995														
	26.7	sites 1,2,3	26.9	all sites	34.3	26.9	211.3	358.8	96.1	82.3	74.2	78.7	hospitals	
		sites 4,5,6	46.4	sites 1,2,3	42.5								outpatient surgeries	
				sites 4,5,6	25.4								home care units	1
3rd Quarter 1995														
	29.6	sites 1,2,3	28.0	all sites	34.3	26.3	212.6	362.1	97.4	85.8	90.8	78.7	hospitals	
		sites 4,5,6	40.4	sites 1,2,3	42.5								outpatient surgeries	
				sites 4,5,6	25.4								home care units	1
4th Quarter 1995														
	26.0	sites 1,2,3	29.3	all sites	34.5	26.7	214.2	367.3	98.9	97.2	98.6	78.7	hospitals	
		sites 4,5,6	39.6	sites 1,2,3	43.2								outpatient surgeries	
				sites 4,5,6	26.1								home care units	1
1st Quarter 1996														
	26.8	sites 1,2,3	29.4	all sites	36.3	26.0	212	355.1	98.1	91.2	84.5	77.6	hospitals	
		sites 4,5,6	33.3	sites 1,2,3	45.5								outpatient surgeries	
				sites 4,5,6	29.4								home care units	1

TOMSK

INDICATORS	1. Share of actual allocations to public health facilities, provided through contracts with the funding source (Health Committees and insurance companies), percentage	2. Outpatient care expenditures as a percentage in total health expenditures in pilot sites covered by **Zdrav***Reform*	3. Share of primary care physicians in the total number of physicians in pilot sites, percentage	4. Referral rate in pilot sites, percentage	5. Number of admissions per 1,000 of the population	6. Number of calls to emergency care stations per 1,000 of the population	7. Scope of disease prevention measures, percentage of groups of population: - pregnant women - pre-school children - schoolchildren			8. Hospital bed capacity in the pilot sites per 10,000 of the population	9. Number of operational day care centers in the pilot sites
1994											
	26.8	27	20	14.7	196	276	na	na	96.6	132	2
1st Half 1995											
City Hospital N3	90	12	15	12.6	174	252	na	na	97	164	na
Polyclinic N1	94	100	60	14	162	214	na	na	94	130	na
Polyclinic N10	96	100	54	13	185	271	na	na	96	107	2
3rd Quarter 1995											
City Hospital N3	90	11.5	16	11	146	194	98	na	na	164	-
Polyclinic N1	94	100	64	15	150	203	96	na	na	120	-
Polyclinic N10	95	98	58	12	162	210	98	na	na	107	2
4th Quarter 1995											
City Hospital N3	90	11	15	12	151	203	97			164	-
Polyclinic N1	93	100	62	15.5	156	220	95			130	-
Polyclinic N10	95	98	57	13	170	236	96			107	2
1st Quarter 1996											
City Hospital N3	94.8	9.7	16	10.5	142	181	97			164	-
Polyclinic N1	95.1	100	65	12	147	194	97			120	-
Polyclinic N10	96.2	98.5	59	12	151	206	98			107	2
2nd Quarter 1996											
City Hospital N3	95.2	10.3	17	9.2	115	152	95			164	2
Polyclinic N1	94	98.3	58	9.6	126	168	91			120	1
Polyclinic N10	96.8	96	54	5.1	113	170	96			107	1
3rd Quarter 1996											
City Hospital N3	93	10	16	9.8	122	160	91			164	2
Polyclinic N1	86	100	61	10.5	145	183	86.6			120	1
Polyclinic N10	96.7	97	57	5.3	114	176	93			107	1

KEMEROVO

INDICATORS	1. Share of actual allocations to public health facilities, provided through contracts with the funding source (Health Committees and insurance companies), percentage	2. Outpatient care expenditures as a percentage in total health expenditures in pilot sites covered by **Zdrav***Reform*	3. Share of primary care physicians in the total number of physicians in pilot sites, percentage	4. Referral rate in pilot sites, percentage	5. Number of admissions per 1,000 of the population	6. Number of calls to emergency care stations per 1,000 of the population	7. Scope of disease prevention measures, percentage of groups of population: - pregnant women - pre-school children - schoolchildren			8. Hospital bed capacity in the pilot sites per 10,000 of the population	9. Number of operational day care centers in the pilot sites
1994											
Kemerovo	30.5	30	25	29	188	300	98.4	98.1	98.6	96.9	20
1st Half 1995											
City Policlinic N5	54.5	100	30	14.5	31.7	na	93.5			na	3
City Policlinic N12	52.7	100	56	12.5	45.2	na	na			na	1
City Policlinic N20	43.3	100	43	17	60.2	134.6	88.3			na	-
Mezhdurechensk CP	26.4	24.9	22	34.6	90	158.6	91.6			76.3	4
Belovo Outp. Facility,	45.1	100	42	19.8	100.7	82.7	90.7			na	2
City Policlinic N1	51.2	22.4	22.8	7.2	87.7	23.6	87			61.4	1
Anzhero-Sudzhenk TMO	87.9	100	25.8	25	109.4	109.4	85.8			100.9	6
Novostroevsk Hospital	40	51.6	18.1	31.4	16	16	93			100.7	-
Krasninsk Hospital	35.5	54.6	36.2	17.2	88	88	76			86.1	4
Yurga Hospital	44.2	25	33.3	23.7	48	48	80.1			162	-
Gippokrat Grp. Practice	83	100	66.7	1.4	8.8	9.2	na			na	-
Tissoul Hospital	38.2	38.2	29	18.1	130.8	120.8	87.4			101.2	2
Kemerovo Hospital N15	70	52.6	30	14.6	78	171	91.5			82	-
3rd Quarter 1995											
2. City Policlinic N5	49.9	100	30.1	12.0	16.6	-	97.8			na	4
3. City Policlinic N12	71.9	100	56	9.8	21.0	21.8	na			na	1
4. City Policlinic N20	26.0	100	50	17.3	29.5	65.3	80			na	na
5. Mezhdurechensk CP	31.3	24.5	20.5	33.2	23.2	70.1	96.2			76.3	14
6. Belovo Outp. Facility,	50.0	72.0	47.7	13.0	15.1	41.3	90			na	3
7. City Policlinic N1	40.6	27.6	26.3	15.7	36.2	12.6	89			61.0	2
8. Anzhero-Sudzhenk TMO	82.0	100	23.6	16.2	44.9	49.0	75			97.0	7
9. Novostroevsk Hospital	51.4	37.7	42.3	23.0	48.6	-	94.6			100	na
10.Krasninsk Hospital	26.0	55.0	39.2	28.0	48.7	50.2	67			86.1	4
11.Yurga Hospital	39.4	40.5	33.3	33.0	35.4	26.0	100			6.2	na
12.Gippokrat Grp. Practice	53.0	95.0	72.7	13.0	5.8	-	na			na	na
13.Tissoul Hospital	22.8	31.0	30.2	29.0	56.1	57.3	92.9			99.1	2
14.Kemerovo Hospital N15	74.6	40.5	26.3	18.0	13.4	-	100			82.0	na

KEMEROVO (CONTINUED)

INDICATORS	1. Share of actual allocations to public health facilities, provided through contracts with the funding source (Health Committees and insurance companies), percentage	2. Outpatient care expenditures as a percentage in total health expenditures in pilot sites covered by **Zdrav***Reform*	3. Share of primary care physicians in the total number of physicians in pilot sites, percentage	4. Referral rate in pilot sites, percentage	5. Number of admissions per 1,000 of the population	6. Number of calls to emergency care stations per 1,000 of the population	7. Scope of disease prevention measures, percentage of groups of population: - pregnant women - pre-school children - schoolchildren			8. Hospital bed capacity in the pilot sites per 10,000 of the population	9. Number of operational day care centers in the pilot sites
4th Quarter 1995											
2. City Policlinic N5	33.2	100	30.1	12	15.8	na	100			na	4
3. City Policlinic N12	20.4	100	56	13.7	na	na	na			na	1
4. City Policlinic N20	19.1	100	50	15.9	na	na	93			na	-
5. Mezhdurechensk CP	29.4	43.5	37.8	28.5	30.4	71.4	94			78.1	5
6. Belovo Outp. Facility,	44	100	48.9	12.4	15	58.2	80			na	5
7. City Policlinic N1	31	28.4	26.3	16	13.7	13.6	98			61.0	1
8. Anzhero-Sudzhenk TMO	79.6	100	30.7	8.3	55.4	54.7	78			na	5
9. Novostroevsk Hospital	na	na	na	na	na	na	na			na	-
10.Krasninsk Hospital	69.4	55.5	39.2	14.5	50.3	53.5	89			87.4	4
11.Yurga Hospital	44.9	23.7	33.3	13	45.2	28	72			125	-
12.Gippokrat Grp. Practice	27.2	100	72.7	5.9	0.6	na	na			na	-
13.Tissoul Hospital	27.2	42	30.2	24	58.7	70.4	85.1			99.1	2
14.Kemerovo Hospital N15	51.9	59.9	23.5	18.4	19.5	na	100			83	-
1st Quarter 1996											
2. City Policlinic N5	36	100	51	10.1	15.7	64.2	97.6			na	4
3. City Policlinic N12	56.8	100	41	51.4	3.2	18.1	na			na	1
4. City Policlinic N20	33	94	30.5	9.0	28.6	na	85			na	-
5. Mezhdurechensk CP	51.1	60.6	37.8	3.0	47.7	70.7	95			76.3	19
6. Belovo Outp. Facility,	42.3	90	41	20	20	56	100			na	2
7. City Policlinic N1	32	39	29	22.8	40	13.0	100			48.6	2
8. Anzhero-Sudzhenk TMO	89	100	23.6	6.2	46.3	72.5	91			103	20
9. Novostroevsk Hospital	63	26	42	2.4	61.8	na	100			100	-
10.Krasninsk Hospital	21.8	88	39	9.4	50.2	44.1	98			82.6	4
11.Yurga Hospital	70	70	21	8.0	33	28	100			129	-
12.Gippokrat Grp. Practice	77.4	100	72	6.1	0.43	na	na			na	-
13.Tissoul Hospital	24.2	47.9	16	7.8	51	76.1	92.3			99.1	34
14.Kemerovo Hospital N15	81	43.5	22	14	40.7	na	100			83	-

NOVOSIBIRSK

INDICATORS	1. Share of actual allocations to public health facilities, provided through contracts with the funding source (Health Committees and insurance companies), percentage	2. Outpatient care expenditures as a percentage in total health expenditures in pilot sites covered by **Zdrav***Reform*	3. Share of primary care physicians in the total number of physicians in pilot sites, percentage	4. Referral rate in pilot sites, percentage	5. Number of admissions per 1,000 of the population	6. Number of calls to emergency care stations per 1,000 of the population	7. Scope of disease prevention measures, percentage of groups of population: - pregnant women - pre-school children - schoolchildren			8. Hospital bed capacity in the pilot sites per 10,000 of the population	9. Number of operational day care centers in the pilot sites
1994											
oblast data	23.4	25	41.4	50	178.4	358.8	98.5	49	92.9	105.7	1
1st Half 1995											
oblast data	25.1	23.2	40.2	25	80.5	180.1	87.1	38.8	25.7	105.7	1
3rd Quarter 1995											
pilot site data	27.2	27.4	13.6	27.2	13.9	65.8	95	12	18	105.3	1
4th Quarter 1995											
pilot site data	27.3	30	12.9	21.8	26.5	71.6	100	75.2	83.4	105.6	1
1st Quarter 1996											
pilot site data	31.6	30	12.9	18.8	13.9	73.8	100	52.5	53.8	105.6	1

APPENDIX 3

LIST OF RUSSIAN EXPERTS ENGAGED IN PILOT PROJECTS.

THIS LIST INCLUDES OVER 75 RUSSIANS UNDER PERSONAL SERVICES AGREEMENTS. THERE ARE AN ADDITIONAL 30 INVOLVED IN PROJECT TEAMS AND TRANSLATION ACTIVITIES THROUGHOUT THE ZDRAVREFORM RUSSIA PROGRAM.

APPENDIX 4

TRAINING SUMMARY

Appendix 4: Training Programs Supported By The ZdravReform Program Of Russia

Training Event	Month	Number	Cum Total:
First Quarter, 1995			
Tomsk Seminar on Fin. Management	Jan	30	30
Polclinic Study Tour to USA	Jan	20	50
Capitation Workshop in Moscow	Feb	16	66
CQD/TQM Seminar in USA	Mar	18	84
Kaluga Financial Modeling Seminar	Mar	20	104
Subtotal for Quarter:		104	104
Second Quarter, 1995			
CQD/TQM Seminar in Novosibirsk	Apr	50	154
HMO Seminar in Kemerovo	Apr	30	184
Duma Roundtable in Moscow	May	20	204
GP Fundholding Study Tour in UK	May	20	224
Workshops on Polyclinics in Germany	May	2	226
Unix Software Training	May	8	234
Moscow GP Conference	Jun	200	434
Rostov on Don Quality Conference	Jun	200	634
St. Pet. Seminar on Public Health	Jun	40	674
USA Operations Analysis Study Tour	Jun	20	694
All Russia Nursing Conference	Jun	200	894
Subtotal for Quarter:		790	894
Third Quarter, 1995			
USA Study Tour for HMOs	Jul	20	914
Cost Accounting Workshop	Jul	28	942
Integration Conference in Novosibirsk	Jul	50	992
Financial Modeling Workshop in Barnaul	Aug	10	1002
Siberian Public Health Association Seminar	Sep	90	1092
Federal Fund Intl Seminar on Insurance	Sep	100	1192
Tomsk Payment Methods Workshop	Sep	40	1232
Subtotal for Quarter:		338	1232

Training Event	Month	Number	Cum Total:
Fourth Quarter, 1995			
Health Insurance and GP Tour in USA	Oct	28	1260
HMO Seminar in Moscow	Oct	40	1300
Quality Seminars in St. Petersburg	Oct	140	1440
Boston MIS Study Tour	Oct	2	1442
Dental Society Managers	Nov	100	1542
Nursing Conference	Nov	20	1562
Modeling Seminar in Tver and Kaluga	Dec	80	1642
WHO Health Reforms in Moscow	Dec	70	1712
Subtotal for Quarter:		480	1712
First Quarter, 1996			
Marketing for Hospitals	Jan	60	1772
Managed Care Contracting in Kemerovo	Jan	40	1812
Managed Care Contracting in Tomsk	Jan	45	1857
Managed Care Contracting in Tver	Feb	60	1917
Bus. Planning for Moscow Womens' Center	Feb	10	1928
Computer Policy Simulation Modeling	Feb	15	1942
Utilization Management in Tver and Tomsk	Mar	95	2037
New Payment Methods in Tver	Mar	25	2062
Cost Acct and Modeling in Tver	Mar	45	2108
Integrated Payment in Kemerovo	Mar	20	2127
Subtotal for Quarter:		415	2127
Second Quarter, 1996			
New Payment Models Workshops in Kaluga	Apr	200	2327
New Payment Models Workshops in Tver Oblast	Apr	200	2527
Healthy Communities Conference	May	100	2627
Kemerovo State Medical Academy training of	May	14	2641
Academy of Natl Econ Insur Training in US	May	17	2658
Software Training on Clinical Patient Records	June	50	2708
Subtotal for Quarter:		581	2708
Total Trained:			**2708**
Total Trained:			**2708**

APPENDIX 5

SUMMARY OF COMPUTER EQUIPMENT PURCHASE

Appendix 5: Summary of Computer Equipment Purchase

Equipment	Total Quantity	Unit Cost	Total Cost
Barnaul			
PC SRV 310 P75	2	$4,336	$8,672
PC SRV 320 P90-MP ready	1	$6,065	$6,065
PC 130 DX4-100/ 540/8MB	18	$1,882	$33,876
PC 130 DX4-100/ 540/8MB	7	$1,882	$13,174
HP Laser Jet 4L	2	$549	$1,098
EPSON LX-100	15	$171	$2,565
ZyXel 1496E+	2	$462	$924
Fax Modem 9600 intern.	7	$275	$1,925
Smart UPS	2	$343	$686
Streamer 250 External	2	$385	$770
BNC Connector	36	$2.20	$79
Terminator MNC 50 Om	12	$2.20	$26
250Mb Tape Backup	10	$24	$240
TP cable, m	4000	$0.70	$2,800
RJ-58 cable, m	1500	$0.88	$1,320
RJ Connector	220	$2.20	$484
BNC 3-plug	20	$2.20	$44
Telephone adapter	7	$1.10	$8
EtherNet NE-2000 adap.	10	$60	$600
PowerChute+ adapter	2	$59	$118
Multiport Card 4 RS-232	2	$200	$400
EtherNet Repeater	1	$275	$275
Active EtherNet Hub 16+	9	$500	$4,500
3-pin socket (220 V)	60	$6	$360
Manual Scanner	1	$200	$200
EtherNet Card NE-2000	52	$40	$2,080
Net Software			
NetWare 3.12/100 users	1	$3,300	$3,300
NetWare 3.12/50 users	1	$3,000	$3,000
Paradox for Windows 4.5	1	$230	$230
FoxPro for Windows 2.6	1	$220	$220
Interbase for NetWare,20	1	$3,800	$3,800
Novell Connect V1.0, 2u	1	$600	$600
Grand Total:			**$94,439**

Equipment	Total Quantity	Unit Cost	Total Cost
Tomsk			
PC SRV 310 P75	2	$4,336	$8,672
PC SRV 320 P90-MP ready	1	$6,065	$6,065
PC 130 DX4-100/ 540/8MB	2	$1,882	$3,764
PC 130 DX4-100/ 540/8MB	16	$1,882	$30,112
PC 130 DX4-100/ 540/8MB	21	$1,882	$39,522
PC 130 DX4-100/ 540/8MB	2	$1,882	$3,764
HP Laser Jet 4L	3	$549	$1,647
EPSON FX-1170	4	$470	$1,880
EPSON LX-300	12	$171	$2,052
ZyXel 1496E+	13	$462	$6,006
Fax Modem 9600 intern.	2	$275	$550
Smart UPS	2	$343	$686
Streamer	3	$187	$561
Streamer 250 External	2	$385	$770
Concentr. Ethernet HUB	8	$160	$1,280
BNC Connector	100	$2.20	$220
Terminator MNC 50 Om	10	$2.20	$22
Crimpling Tools	1	$55	$55
250Mb Tape Backup	10	$24	$240
Diskettes 3.5"	150	$0.77	$116
Toner	5	$77	$385
Glass filter	42	$6	$252
RJ-58 cable, m	3000	$0.88	$2,640
Grand Total:			**$111,261**
Novosibirsk			
PC 130 DX4-100/ 540/8MB	4	$1,882	$7,528
HP Laser Jet 4L	4	$549	$2,196
Fax Modem 9600 intern.	4	$275	$1,100
Streamer 250 External	4	$385	$1,540
Grand Total:			**$12,364**

Equipment	Total Quantity	Unit Cost	Total Cost
Kemerovo			
LAN Server	1	$59,656	$59,656
PC SRV 320 P90-MP ready	1	$6,065	$6,065
PC 130 DX4-100/ 540/8MB	2	$1,882	$3,764
PC 130 DX4-100/ 540/8MB	42	$1,882	$79,044
HP Laser Jet 4L	3	$549	$1,647
EPSON LX-1050	7	$291	$2,037
EPSON LX-300	34	$171	$5,814
Fax Modem 9600 intern.	2	$275	$550
Streamer 250 External	3	$385	$1,155
Centronics cable	42	$4.40	$185
BNC Connector	40	$2.20	$88
250Mb Tape Backup	1	$24	$24
TP cable, m	1800	$0.70	$1,260
Coax cable, m	600	$0.88	$528
RJ Connector	60	$2.20	$132
T connector	10	$2.20	$22
Oracle 7 with tools	14	$4,705	$65,870
Grand Total:			**$168,185**

APPENDIX 6

DESCRIPTION OF FINANCE MODELS

Appendix 6: Description of Finance Models

The ZdravReform Program has investing in the development, implementation and evaluation of seven types of health financing working models. These seven models are:

Model 1. New methods of payment to outpatient facilities:

There are three principal methods being used in the pilot sites:

- Partial fund-holding scheme: Polyclinic is capitated for provision of all outpatient care, including lab tests, specialist referrals, diagnostic procedures, emergency care
- Full fund-holding scheme: Polyclinic is capitated for provision of all medical care, including the bulk of inpatient care and all outpatient care
- Relative Value Scale for payment to dentist care facilities

Model 2. Inpatient care payment methods

There are three principal methods being used in the pilot sites:

- Retrospective payment for each finished case across diagnostically-related groups
- Global budgets for hospitals that are case-mix adjusted
- Performance-related hospital staff compensation formula

Model 3. Managed care model that integrates insurance and care delivery:

These fully integrated models are similar to US HMOs, and encompass work to:

- Form an integrated system of health care delivery for the insurers' subscribers
- Establish new managerial and operational bodies linking the purchaser and providers
- Test integrated payment scheme
- Cost and utilization management systems
- Outcome reporting systems

Model 4. Integrated costing methods

- Establish software and protocols for cost accounting system for management
- Cost analysis and financial planning at pilot hospitals
- New resource reallocation among departments in the pilot hospitals

Model 5. Restructuring polyclinics into more cost effective, consumer responsive private physician practices:

- Establish free-standing GPs within and outside existing polyclinic sites
- Ensure family orientation of primary care provision
- Change the role and reallocate the resources of polyclinics
- Performance-related polyclinic staff compensation systems

Model 6. Multilevel system of inpatient care:

This model of care evaluation and planning encompasses work to:

- Separate acute and sub-acute inpatient care
- Ensure continuity of care for early hospital discharges to new care settings
- Pay for completed cases of acute and sub-acute inpatient care

Model 7. Financial modeling for designing and pricing medical benefits packages for mandatory medical insurance

- Develop new methodology of costing medical benefits for Territorial Health Insurance Funds
- Test the methodology under different scenarios of resource utilization for improving the structure and efficiency of care provision at oblast level funding

APPENDIX 7

MATRIX OF RUSSIA TECHNICAL PROGRAM PRODUCTS

Matrix of Russia Technical Program Products

File Name	Language	Product Name	Technical Advisor	Counterparts
Management				
MANUALS				
MMN002	Russian	Practical Guidelines for Contract Development and Implementation in Health Care	Makarova	Banin
MMN003	Russian	Development of General Practices in Polyclinics (Tomsk working model)-methodological recommendations	Makarova	Gabdrahimova
MMN003A	Russian	Development of GPs in MHI Enviroment (Methodological Recommendations), Tomsk	Makarova	Banin
MMN004	Russian	Development of General Practices in/near Polyclinics - manual, Kemerovo	Sheiman	
MMN005	English/ Russian	Case Grouping and Rate Setting from a Perspective of Incentive-Based Reimbursement for Inpatient Care	Telyukov	
MMN006	English, Russian	Utilization Management	Leavitt	Mike Delbar
MMN007	Russian	Development of Multi-Level Delivery System	Sheiman	
CASE STUDIES				
MCS001	Russian	Developing and Testing Methods of Economic Evaluation for Alternative Medical Treatment Technologies		Babarykina

Matrix of Russia Technical Program Products

File Name	Language	Product Name	Technical Advisor	Counterparts
MCS004	Russian	Manual on Financial Modeling	Woodard	Frid
SOFTWARE				
MSW001	English/ Russian	A Guide to Methodology: Integrated System of Cost Accounting and Analysis for Inpatient Care Providers, Developed and Implemented at the Tomsk Oblast Technical Hospital	Telyukov	
MSW002	English/ Russian	Cost Accounting System for DOS	Telyukov	
TRAINING MATERIALS				
MTM002	English	Contracts Workshop	Leavitt	Mike Delbar
PAPERS AND PUBLICATIONS				
MPP002	English/ Russian	New Contracting for Health Gain: A Discussion Paper for Developing Health Insurance and Health Services Purchasing	Rice	
MPP002A	Russian	Approaches to Forming an Intergrated System of Health Finance and Delivery	Sheiman	
MPP003	English/ Russian	Contracting Models and Provider Competition in Europe	Rice/Sheiman	
MPP004	English/ Russian	Modern Marketing Concepts for Health Care Organizations of the Former Soviet Union	Rice	
MPP005	English/ Russian	Design Factors for NIS Health Insurance Agencies	Rice	
MPP006	English/ Russian	Restructuring Polyclinics in East Germany, Implications for Russia	Sheiman	

Matrix of Russia Technical Program Products

File Name	Language	Product Name	Technical Advisor	Counterparts
MPP008	English	Preparation of Managers for Twenty-First Century Health Care in Russia	Waley	
Finance/Resource Management				
MANUALS				
FMN002	Russian	Medical Insurance Integrated Systems	Sheiman/ counterparts	Natalia Nelepina
FMN003	Russian	Elaboration and Usage of New Payment Methods	Sheiman/ counterparts	Ludmila Isaakova
FMN005	Russian	Costing Medical Benefit Packages	Sheiman/ counterparts	
CASE STUDIES				
FCS001	Russian English	Global Budgets for Hospitals (British Model)	Dredge	
FCS002	Russian	New Payment Methods for Hospitals (Tomsk working model)	Makarova/ Gabrahimova	Gabdrahimova
TRAINING MATERIALS				
FTM002	English Russian	Alternative Payment Methods - a one week workshop (2 volumes)	Langenbrunner	
FTM003	English Russian	Financial Modelling Workshop	Langenbrunner Woodard	Edward Frid
FTM004	English Russian	Case-Mix Adjusters Workshop	Langenbrunner	
PAPERS AND PUBLICATIONS				
FPP001		Vol 2: AUPHA Special for Russia Provider Payments Introduction	Rice/Roberts	
FPP002		The Context of Provider Payment Reforms in the Russian Federation: A Challenging Arena for Managerial Development for Twenty-First Century Russia	Semenov et al.	
FPP003		A Framework for Developing Russian Health Accounts	Fischer/ Patterson	

Matrix of Russia Technical Program Products

File Name	Language	Product Name	Technical Advisor	Counterparts
FPP004		Hospital Payment Policies and Reforms: Issues and Options in Russia	Langenbrunner et al.	
FPP005	Russian	Methods of Payments for Outpatient Care	Sheiman et al.	
FPP006	Russian	Cost Finding and Market Oriented Pricing of Medical Services in Russia: New Issues and Options	Makarova	
FPP007		Capitation and Integrated Systems	Rice et al.	
FPP009	Russian	Russian Integrated Payment Approaches	Sheiman	
WORKING PAPERS				
FWP001	Russian	Restructuring Polyclinics into Freestanding General Practices	Sheiman	
FWP002	Russian	Final Report: Summary of Alternative Payment Methods for Polyclinics	Sheiman	
FWP003	Russian	Final Report: Summary of HMO Activities	Sheiman	
FWP004	Russian	Final Report: Summary of Alternative Payment Methods/Accomplishments in Tomsk Oblast	Makarova	

Quality Development

MANUALS				
QMN001	English Russian	Manual of Clinical Quality Improvement for the Transformation of the Russian Health Care System	Tillinghast	

Matrix of Russia Technical Program Products

File Name	Language	Product Name	Technical Advisor	Counterparts
CASE STUDIES				
QCS001	English	Continuous Quality Improvement Projects in Siberian Oblast Hospitals: Medical Director's Report	Tillinghast	
QCS002	English	Health Care Quality Management Implementation Report: Central Russia	Tillinghast	
TRAINING MATERIALS				
QTM001	English Russian	CQI Workshop (5 Days)	Coffey	
QTM002	Russian	CQI/Indicators Workshop (2 Days)	Tillinghast	
QTM003	English	Infection Control Workshop	Tillinghast	Carol O'Boyle Edward O'Rourke
WORKING PAPERS				
QWP001	Russian	CQD Pilot - Reducing LOS for MI	Tillinghast	Anatoly I.Starkov
QWP002	Russian	CQD Pilot - Rational Pharmacy	Tillinghast	Valery A. Nechaev
QWP003	Russian	Optimization of Health Care and Diagnostic Arrangements for Patients with Arterial Hypertension	Tillinghast	Valery A. Nechaev
QWP004	Russian	TQM of Medical Care Delivery of Acute Pneumonia	Tillinghast	Valery A. Nechaev
QWP005	Russian	Ambulatory Indicators	Tillinghast	Ia A. Yegorova, Tatiana I.Drachieva
QWP006	Russian	Decreasing the Length of Stay After Myocardial Infarction	Tillinghast	Andrey V.Tereschenko
QWP007	Russian	Leadership of the Activities Related to Medical Care Quality Management in Novosibirsk Oblast	Tillinghast	Mikail N.Melnikov

Matrix of Russia Technical Program Products

File Name	Language	Product Name	Technical Advisor	Counterparts
QWP008	Russian	CQD Pilot-Infection Control	Tillinghast	Yevgeny F.Bocharov
QWP009	Russian	Introduction of Medical Care Quality Assurance and QM System and Medical Services in a Multi-Profile Medical Facility	Tillinghast	Irina N.Nagornaya
QWP010	Russian	Analyzing CQI Experience in Kemerovo	Tillinghast	Galina N.Tsarik
QWP011	Russian	Development of the Questionnaire Regarding the Degree of Patient Satisfaction in Kemerovo	Tillinghast	Galina N.Tsarik
QWP012	Russian	CQD Pilot - Reducing LOS for MI	Tillinghast	Nikolai I.Tarasov
QWP013	Russian	Uninterrupted Quality Improvement at the Kemerovo Regional Hospital	Tillinghast	Galina V.Kirilkina
QWP014	Russian	CQD Pilot- Tomsk #1	Tillinghast	Sergey M.Khlynin
QWP015	Russian	CQD Pilot - Tomsk #2	Tillinghast	Sergey M.Khlynin
QWP016	Russian	Development of Formualries to Treat Ulcer	Tillinghast	Yelena L.Akulova
QWP017	Russian	CQD Pilot - Reducing LOS for MI	Tillinghast	Arkady N.Prikhodko
QWP018	Russian	Ambulatory Indicators	Tillinghast	Sergey M.Khlynin

Information Systems

MANUALS				
IMN001	English	Health Information Systems Design and Overview	Woodard	Anatoliy Vorobjev
IMN002	English	The Medical Information System for Tver Oblast. The	Vorobjev	

Matrix of Russia Technical Program Products

File Name	Language	Product Name	Technical Advisor	Counterparts
	Russian	World Bank Loan Project. Concept		
IMN003	English Russian	Territorial Health Fund Information Software: The Insurance Benefits Manager Package	Woodard	
IMN004	English Russian	Clinical Patient Record System (HMO and Polyclinic) (Kemerovo, Barnaul)	Woodard	
SOFTWARE				
ISW001	Russian	Clinical Patient Record System (HMO and Polyclinic) (Kemerovo, Barnaul)	Woodard	
ISW002	Russian	Health Insurance System (Beneficiary Tracking System) (Kemerovo)	Woodard	
ISW003	Russian	CD-ROM Library	Woodard	
PAPERS AND PUBLICATIONS				
IPP001		Information Systems Needs for Reform	Woodard	

Policy (General)

PAPERS AND PUBLICATIONS				
PPP001		Collaboration: What Makes it Work	Wilder Foundation	
PPP003	English	A Call for a New Social Compact in the Former Soviet Union	Rice	
PPP004		Building Health Promotion into Health Care Reform in Russia	Tillinghast	
PPP005		The Babushkas 101 Ways to Survive the Challenges of Health Sector Reform in Russia	Rice	
PPP006	English/ Russian	Developing New Integrated Health Care Delivery and Funding Systems in Russia	Rice/Sheiman	
PPP007	English	Kemerovo: Ten Years of Change and Innovation of Health Care	Rice	

Matrix of Russia Technical Program Products

File Name	Language	Product Name	Technical Advisor	Counterparts
Reference Materials				
rus001	English	International Center of Health Policy and Legislative Initiatives (Draft)		
rus002	English	Federal Law of the Russian Federation "On the Rights of the Patient"		
rus003	English	Federal Law "On the Introduction of Amendments and Additions into the Law of the Russian Federation", "On the Medical Insurance of Citizens in the Russian Federation"	Denisenko	
rus004	English	Russian Federation Federal Law "On the Natural Medical Resources, Health Improvement Localities and Resorts		
rus005	English	Russian Federation Federal Law "On Prevention of Spread of Disease Caused by Acquired Immune Deficiency Syndrome (AIDS) Virus in the Russian Federation"		
rus006	English	Draft Law in the Russian Federation "On Private Medical Practice and Private Health-Related Activities"		
rus007	English	Standing Orders on Licensing of Medical Activities		
rus008	English	Russian Federation Federal Law "On Circulation of Narcotics"		
rus009	English	Russian Federation Federal Law of Remedies (Draft)	Denisenko	

Matrix of Russia Technical Program Products

File Name	Language	Product Name	Technical Advisor	Counterparts
rus010	English	Russian Federation Federal Law "On Medicinal Drugs" Extract from Protocol No. 123 of State Duma Council Meeting of Federal Assembly of Russian Federation	Malakhatkina	
rus011	English	Russian Federation Federal Law About Inserting Amendments and Additions into the RSFSR Criminal Code, RSFSR Criminal and Proceedings Code, RSFSR Code on Violation of Administrative Law, and into the Law of the Russian Federation		
rus013	English	Development of the Mandatory Health Insurance System in the Russian Federation	Semyonov	
rus015	Russian	Non-Profit Companies Draft Law. Prague		
rus017	English	Saving and Protecting the Health of the People (Resolution of the All-Russia Pirogov Congress of Physicians)		
rus018	Russian	USA Federal Law on Subcontractors		
rus019	Russian	Oblast Health Care Reform Report Form		
rus021	English, Russian	On Health Care Reform in Tver Oblast. Ordinance 730-p	Platov	
rus022	English	Conceptual Framework for Health Policy Planning Within Russia	Rice	

Matrix of Russia Technical Program Products

File Name	Language	Product Name	Technical Advisor	Counterparts
rus023	English, Russian	Country Action Plan for Four Siberian Oblasts. Project Goal, Purposes and Expected Outcomes		
rus024	Russian	Primary Care Development in US. 1996 Overview		
rus101	Russian	Managed Care Approach (overheads)	Sheiman	
rus102	Russian	Managed Care Organizations. Legal Answer Book for Managed Care		
rus103	English, Russian	HMO. Requirements for Health Maintenance Organizations		
rus104	Russian	HMOs in Russia		
rus105	English	Agreement on Development of the Integrated Health Care Delivery and Funding System (HMO) Master Copy		
rus106	English	The Comparative Mangaed Care Case Study Questionnaire	Telyukov	
rus201	Russian	Computer Quality Improvement System Within One Year	Harris	
rus202	English	Information System. Strategy and Program		

Matrix of Russia Technical Program Products

File Name	Language	Product Name	Technical Advisor	Counterparts
rus203	English, Russian	Concept. Medical Information System (MIS) for Tver Oblast		
rus205	English	Medical Information Systems for Tver Oblast. The World Bank (Expert Comments)	Malkov	
rus303	Russian	Principles and Practice of Using Modern Manager and GP Compensation Systems: Relevance for Russian Reform	Wegmiller	
rus307	Russian	Methods of Funding and Requirements to QA (overheads)	Sheiman	
rus309	Russian	Maryland's Rate Setting Program		
rus311	Russian	Payment Methods Development & Testing: Outpatient Care Delivery, Kemerovo Report		
rus313	Russian	Utilization Management at Health Insurance Associations: Approaches, Methods, Activites	Sheiman	
rus314	Russian	Manual on Development and Implementation of Outpatient Payment Model	Zakirov	
rus404	Russian	Chilean Health Care: Organization, Operation and Funding	Castagneda	
rus410	Russian	Developing and Costing the Territorial MHI Program	Sheiman	

Matrix of Russia Technical Program Products

File Name	Language	Product Name	Technical Advisor	Counterparts
rus411	Russian	Developing and Costing the Territorial MHI Program in Altai Krai	Sheiman	
rus413	Russian	Prices of Medical Services	Makarova	
rus414	Russian	Basic Rules and Issues of Introducing New Methods of Payment in MHI System	Makarova	
rus415	English	Developing Health Finance Indicators for the States of the Former Soviet Union	Sheiman	
rus418	English, Russian	Health Care Reform in Great Britian	Zelkovich	
rus501	English	The Methodology of Measuring Potential Health Care Demands in Populations	Kravchenko	
rus502	English, Russian	A Framework for the Continual Improvement of Health Care	Batalden	
rus503	Russian	Assessment of Appropriateness of Hospital Utilization	Restuccia	
rus505	Russian	Managed Care System Development Trends	Bartling	
rus507	Russian	Principles of Problem Solving in Health Services. Minnesota. Hospital and Health Facility Mangement Program		

Matrix of Russia Technical Program Products

File Name	Language	Product Name	Technical Advisor	Counterparts
rus509	English	Mandatory Health Insurance System. Concept of Formation and Development		
rus510	English	The Health Reform Strategy in the Changed Economic Environment	Tsaregorodtsev	
rus511	Russian	Hospital Policy Strategic Planning	Folkson	
rus512	Russian	Essentials of Managed Health Care. New Contracting for Health gain. What is Involved in the Preparation for Negotiations?		
rus513	Russian	Types of Managed Care Organizations	Wagner	
rus514	Russian	Essentials of Managed Health Care		
rus515	English	Woman's Health Center. The Strategic Business Plan		
rus516	Russian	Strong Medicine	Halvorson	
rus517	English	Improving Management of Health Facilities. Report. USSR Ministry of Health	Korchagin	
rus518	Russian	Establishing Effective Incentives	Aksin	

Matrix of Russia Technical Program Products

File Name	Language	Product Name	Technical Advisor	Counterparts
rus519	Russian	Basic Contract		
rus520	English, Russian	Key Industry Facts. Health Care in the US		
rus521	Russian	Independent Primary Care Structures in US	Rice	
rus522	English, Russian	A Word of Comment on Mr. James A. Rice's Article "A New Social Compact in the Fomer Soviet Union"	Sheiman	
rus523	Russian	GP Leadership Tasks in Modern Integrated Health Care Systems	Wegmiller	
rus525	English	Family Dispensary: Structure and Fuctions. Methodological Recommendations	Finchenko	
rus526	English	Family Practitioner and Family Practitioner's Catchment Area. Methodological Recommendations	Finchenko	
rus527	English, Russian	Role of MHI in Health Reform. Presentation at Moscow International Seminar	Rice	
rus533	English	New Accountablities for Health Gain. A Concept Paper		
rus535	Russian	Health Sector Management Capacity Building in Central and Eastern Europe. Special Issue	Rice	

Matrix of Russia Technical Program Products

File Name	Language	Product Name	Technical Advisor	Counterparts
rus702	Russian	Treatment Outcomes and Treatment Process Ratio	Kazandjan	
rus703	Russian	Practical Manuals in Continual Quality Improvement	Kibb	
rus704	Russian	Medical Services Quality Evaluation: Comparative Data for Evaluation of Prophylactic Measures	Heinen	
rus705	Russian	Health Facility Work Improvement Based on Statistical Analysis	Nazdam	
rus706	English, Russian	Report Card	Leatherman	
rus708	English	Health Care Quality, Problems and Prospects of Assuring Quality Guarantees Within Mandatory Health Insurance System	Chavpetsov	
rus709	Russian	Drug Use Review		
rus710	Russian	Quality Assurance: Group Practice		
rus712	Russian	Quality Assurance and Accreditation	Donahue	
rus713	English	Perfection of the Regulatory Base of Health Care Delivery Under Mandatory Health Insurance System		

Matrix of Russia Technical Program Products

File Name	Language	Product Name	Technical Advisor	Counterparts
rus714	Russian	Clinical Practice Guideline for Adult Cholesterol Management		
rus715	Russian	Guidelines for Hypercholesteral Management. Rationale & Advice	Tillinghast	
rus717	Russian	Outpatient Treatment of Adult Asthma	Klerrup	
rus718	Russian	The Health Care Quality Improvement Initiative	Jenks	
rus719	Russian	Clinical Practice Guidelines for the Management of Asthma in Children		
rus720	Russian	Managing Unstable Angina. Patient and Family Guide		
rus721	Russian	Guidelines for Screening, Evaluation and management of Adult Hypertension		
rus722	Russian	Guidelines for the Diagnosis and Management of Asthma		
rus723	Russian	Quality Assurance and Risk Adjustment Program		
rus724	Russian	A Set of Patient Lab Testing Forms		

Matrix of Russia Technical Program Products

File Name	Language	Product Name	Technical Advisor	Counterparts
rus725	Russian	Clinical Care Improvement Program. Managed Care for Cost Efficiency, Quality Improvement & Broader Access. Anticipated Recovery Paths	Upson	
rus726	Russian	Performance-Based Health Facility Accreditation System. Beta-Testing & In-Hospital indicators. Hosptial Accreditation Manual		
rus727	English, Russian	Linking Outcomes Measurement to Continual improvement: The Serial "V" Way of Thinking About Improving Clinical Care	Batalden	
rus728	English	Quality Improvement in Russian Health Care: New Tools for a New Task	Tillinghast	
rus802	English	Type Curriculum and Higher Education Specialist Training Program to Do the Job as "General Practitioner (Family Doctor)"		
rus803	Russian	On the GP Status in Russia	Makarova	
rus804	English, Russian	Briefing Notes on General Practice Fundholding	Atun	

APPENDIX 8

MATRIX OF RUSSIA GRANT PROGRAM PRODUCTS

Matrix of Russia Grant Products

File Name	Title	Technical Advisor	Counterparts
Establishment of Free-Standing General Practices			
ASOPO Zhizn Insurance Company			
GP301D3	Document that outlines the job descriptions, roles and responsibilities of the private physicians and their assistants	Makarova	Ivaninskaya
GP301D4	Agreement on Rent of a Non-Residential Area	Makarova	Ivaninskaya
GP301D5	Document that describes the legal, policy and administrative changes that were needed to establish the private practices.	Makarova	Ivaninskaya
GP301D8	Document summarizing in detail the private practices' office budgets, estimates of physician productivity, the methodology for calculating capitated payments and the level of capitated payments made to physicians	Makarova	Ivaninskaya
Altai Krai Health Care Committee			
GP303D1	Report describing the need for and the conceptual framework for restructuring polyclinics and the constraints to restructuring that exist in the current legislation.	Sheiman	Elikomov
GP303D2	Draft legislation and regulatory documents in Russian, approved by local government authorities, permitting the formation of free-standing primary care practices staffed by self managed family practice physicians.	Sheiman	Elikomov
GP303D3	Standard contracts to govern the working relationships between the free standing practice and the polyclinic.	Sheiman	Elikomov

Matrix of Russia Grant Products

File Name	Title	Technical Advisor	Counterparts
GP303D4	Standard contract between GP and 3rd party payer.	Sheiman	Elikomov
GP303D6	Document describing procedures for open enrollment, quality assurance and for licensing and accreditation of general practitioners.	Sheiman	Elikomov
GP303D7	Document describing the training curricula, facilitator's guide and training materials used to train thirty physicians as family practice physicians.	Sheiman	Elikomov
Tula-Albany Health Care Insurance Company			
GP400D2	Document describing the regulatory acts on setting up an HMO.	Sheiman	Tubinshlak
GP400D3	Document describing the business plan.	Sheiman	Tubinshlak
GP400D4	Document with examples of actual contracts with hospitals and with facilities providing specialty care (e.g. psychiatric, maternity and tuberculosis care)	Sheiman	Tubinshlak
GP400D6	Detailed specifications for an information system to support delivery of health services under a managed care model and copy of functioning software.	Sheiman	Tubinshlak
MedExpress Insurance Company			
GP404D1	Document describing strategies used by general practitioners to reduce the rate of hospitalization among their patients.	Makarova	Schneiderman
GP404D2	Document describing the incentive system used by the insurance company to reduce the rate of hospitalization among patients of the general practice.	Makarova	Schneiderman

Matrix of Russia Grant Products

File Name	Title	Technical Advisor	Counterparts
GP404D3	Document describing all legal and regulatory steps taken to license general practice and to implement new quality control and incentive payment systems, including references to all laws cited as a legal basis for these steps.	Makarova	Schneiderman
Development of New Payment Methods			
Kemerovo Institute of Social and Economic Problems of Health Care			
PM302D1	Report summarizing international experience in using DRG-based systems to pay for out-patient care and recommended methods for developing a DRG-based system for use in Russia.	Tillinghast	Tzarik
PM302D2	Report summarizing results of retrospective analysis of most frequent reasons for seeking out-patient treatment and treatment provided in the out-patient setting in Kemerovo.	Tillinghast	Tzarik
Tomsk Health Care Committee			
PM305D1	A document detailing a new approach and method for costing hospital care.	Makarova	Gabrahimova
PM305D2	A document describing alternative methods for making payments to different types of hospitals, recommended strategies for implementing alternative payment methodologies, recommended approaches to setting universal versus hospital-specific rates.	Makarova	Gabrahimova
PM305D3	A manual describing methodologies for adjusting hospital rates to the amounts paid for medical benefits provided under the Territorial Program of MHI.	Makarova	Gabrahimova
PM305D4	A report describing the development of performance-based systems of prospective payments and the development of grouping methodologies for several high volume cases.	Makarova	Gabrahimova
PM305D5	A test of a new payment methods in pilot hospitals and a document describing the protocol for the field test and the results of that test.	Makarova	Gabrahimova

Matrix of Russia Grant Products

File Name	Title	Technical Advisor	Counterparts
PM305D6	A document describing principles and methods of contracting with hospitals.	Makarova	Gabrahimova
Vladivostok Municipal Hospital No. 2			
PM408D1	Technical training document that describes cost accounting, cost allocation and invoicing procedures adopted by the hospital to improve the hospital's ability to function under a system of health insurance financing.	Woodard	Karepin
PM408D2	Document describing technical specifications for all network hardware and software used to implement information system for cost accounting and invoicing.	Woodard	Karepin
Kaluga Mandatory Health Insurance Fund			
PM434D1	Description of New Payment Methods	Sheiman	Omelchenko
PM434D2	Description of Analytic Tools developed which may include Financial/Demand Modeling, Cost Accounting Methods, Utilization Management, Refining Case-Mix Measures, Clinical Care Mapping.	Sheiman	Omelchenko
PM434D4	Description of Quality Indicators	Sheiman	Omelchenko
PM434D5	Copies of Model Contracts developed for payer, facilities, and staff	Sheiman	Omelchenko

Matrix of Russia Grant Products

File Name	Title	Technical Advisor	Counterparts
PM434D6	Descriptions of Quality Improvement Approaches and Indicators for Hospitals	Sheiman	Omelchenko
PM434D7	Copy of Database and Sample Reports	Sheiman	Omelchenko
Tver Oblast Mandatory Health Insurance Fund			
PM435D1	Description of New Payment Methods	Makarova	Zlobin
PM435D2	Description of Analytic Tools developed which may include Financial/Demand Modeling, Cost Accounting Methods, Utilization Management, Refining Case-Mix Measures, Clinical Care Mapping.	Makarova	Zlobin
PM435D3	Description of Quality Indicators.	Makarova	Zlobin
PM435D4	Documentation of Terms of Reference for Creation of Councils for Quality Improvement.	Makarova	Zlobin
PM435D6	Descriptions of Quality Improvement Approaches and Indicators for Hospitals.	Makarova	Zlobin
PM435D7	Copy of Database and Sample Reports	Makarova	Zlobin
Cherepanovo District Hospital and Novosibirsk Oblast MHIF			
PM436D1	Cost Accounting System document	Millburn	Kim, Melnikov
The Tula Territorial Fund of Mandatory Health Insurance			

Matrix of Russia Grant Products

File Name	Title	Technical Advisor	Counterparts
PM437D1	Charter, Agreement, Decision from City/Oblast for creation of new polyclinic	Sheiman	Tubinshlak
PM437D2	Contracts between 1) HMO and primary health care physicians, 2) HMO and hospital, 3) HMO and other hospitals with which services will be contracted	Sheiman	Tubinshlak
PM437D3	Payment Tracking Software	Sheiman	Tubinshlak
Dissemination and Leadership Development			Tubinshlak
Saint Petersburg Medical Academy			
LD418D1	A graduate syllabus for health facility leaders related to the fundamentals of economics, market economy relations in health care, health insurance organization, and entrepreneurship basics.	Rice	Filatov
LD418D2	A graduate syllabus for health facility leaders related to modern economic analysis and optimyzing the health facility economic performance.	Rice	Filatov
LD418D3	A graduate syllabus for health facility leaders related to modern methods of health care management and marketing.	Rice	Filatov
LD418D4	A manual on statistical and economic analysis to provide for rationalizing the economic and clinical performance of health facilities.	Rice	Filatov
LD418D5	A chapter on application of health management data processing software	Rice	Filatov

Matrix of Russia Grant Products

File Name	Title	Technical Advisor	Counterparts
LD418D6	A manual on risk management at health facility.	Rice	Filatov
LD418D7	A manual on the basics of management at health facility.	Rice	Filatov
Regional Fund of Compulsory Medical Insurance, Rostov Oblast			
LD419D1	Documents on the results of consultations with experts on developing curricula for training managers of independent quality evaluation.	Milburn	Evdokimov
LD419D2	Materials of orientation workshop of health care managers of Rostov oblast	Milburn	Evdokimov
LD419D3	Curricula for training managers of medical and economic evaluation of quality of health care.	Milburn	Evdokimov
LD419D5	Training schedule and report on the results of pilot training of health care quality managers for non-departmental expert committee of Rostov oblast.	Milburn	Evdokimov
LD419D7	Draft of business plan for establishing regular courses in health care quality management.	Milburn	Evdokimov
LD419D8	Draft of the “Provision on Independent Expert Evaluation of Quality of Health Care in Rostov Oblast.”	Milburn	Evdokimov
LD419D9	Quality control-related materials published in mass media.	Milburn	Evdokimov
LD419D10	Description of quality control in medical facilities in Rostov	Milburn	Evdokimov

Matrix of Russia Grant Products

File Name	Title	Technical Advisor	Counterparts
Association of Don Physicians			
LD420D1	Six issues of the newsletter	Milburn	Simakov
LD420D2	Database of newsletter recipients	Milburn	Simakov
LD420D3	Database of health care professionals and organizations in Rostov region	Milburn	Simakov
LD420D5	Action plan for creation of federal physicians newsletter	Milburn	Simakov
Regional Educational-Methodological Center of the Far Eastern Medical Association			
LD421D1	Methodological brochures and manuals for students and trainees on Economics and Health Insurance Organizations	Milburn	Kapitonenko
LD421D2	Methodological brochures and manuals for students and trainees on Health Care Quality Evaluation	Milburn	Kapitonenko
LD421D3	Methodological brochures and manuals for students and trainees on Social off-Budget Funds	Milburn	Kapitonenko
LD421D4	Methodological brochures and manuals for students and trainees on Health Care Economics and Finance	Milburn	Kapitonenko
LD421D5	Healthcare Newsletters (3 issues)	Milburn	Kapitonenko

Matrix of Russia Grant Products

File Name	Title	Technical Advisor	Counterparts
LD421D6	Materials for workshops and conferences	Milburn	Kapitonenko
LD421D7	Financial Problems of Healthcare Reform, and the Development of Medical Insurance System on the Regional Level	Milburn	Kapitonenko
LD421D8	Informational Database on the Functioning of the Medical Insurance Sytem in Healthcare Institutions	Milburn	Kapitonenko
Leadership Training Center Under "MedSocEconInform" Public Health Institute			
LD424D1	Grant program implementation process will be covered in mass media, specifically in the magazine Zdravookhraneniye Rossiyskoy Federatsii (Health Care of the Russian Federation).	Rice	Miasoedov
LD424D2	Publication on experience gained in leadership training.	Rice	Miasoedov
Academy of National Economy Under the Government of Russian Federation Business Management Center, Institute for Senior Executives			
LD425D1	20-min. educational video on the health leader upgrading program	Rice	Mozharov
LD425D2	Upgrading outcomes reports for Groups 1,2,3	Rice	Mozharov
LD425D3	Manuals displayed at the international exhibition "World Business School '96"	Rice	Mozharov
Siberian Fund of Management Development			

Matrix of Russia Grant Products

File Name	Title	Technical Advisor	Counterparts
LD426D2	Methodological manual "Health Economics"	Milburn	Isakova
LD426D3	Computer educational program on mandatory medical insurance	Milburn	Isakova
LD426D4	Computer educational program on health economics	Milburn	Isakova
LD426D5	Methodological manual "Statistics in Health and Medical Insurance"	Milburn	Isakova
LD426D6	Methodological manual "Medical Insurance"	Milburn	Isakova
LD426D7	Methodological manual "Personnel Management"	Milburn	Isakova
LD426D8	Computer educational program on statistics in health and medical insurance	Milburn	Isakova
LD426D9	Computer educational program on medical insurance	Milburn	Isakova
LD426D10	Methodological manual "Voluntary Medical insurance"	Milburn	Isakova
LD426D11	Methodological manual "Health Management and Marketing"	Milburn	Isakova

Matrix of Russia Grant Products

File Name	Title	Technical Advisor	Counterparts
LD426D12	Methodological manual "Health Organization"	Milburn	Isakova
Novosibirsk State Academy of Economy and Management			
LD427D1	Strategic management, and planning. (programs, methodological recommendations for test work, lectures)	Milburn	Gusev, Shemetev
LD427D2	Health care organization. (work program only)	Milburn	Gusev, Shemetev
LD427D3	Health care management. (work program, lectures)	Milburn	Gusev, Shemetev
LD427D4	Financial management in health care. (work program, tests)	Milburn	Gusev, Shemetev
LD427D5	Marketing of health services. (work program, tests)	Milburn	Gusev, Shemetev
LD427D6	Quality of health services. (work program, tests)	Milburn	Gusev, Shemetev
LD427D7	Information systems in health care. (work program, tests)	Milburn	Gusev, Shemetev
LD427D8	Regional management of health care. (work program, tests)	Milburn	Gusev, Shemetev
LD427D9	Sociology and psychology of management. (work program, lectures, tests)	Milburn	Gusev, Shemetev

Matrix of Russia Grant Products

File Name	Title	Technical Advisor	Counterparts
LD427D10	Strategy design, comparison of business plan and budget. (methodological instructions on how to develop a course)	Milburn	Gusev, Shemetev
All-Russia Nurses Association			
LD430D1	Working papers that detail the bylaws of the ARNA including the philosophy and goals.	Milburn	Sarkisova
LD430D2	Working papers that detail the organizational structure including its working groups and their subgroups.	Milburn	Sarkisova
LD430D3	Working papers that detail the embodiment of the nursing organizations, plans for membership recruitment, and organizational plans.	Milburn	Sarkisova
LD430D4	Creation of nursing standards and job descriptions for nurses of the Russian Federation done in cooperation with the Ministry of Health.	Milburn	Sarkisova
LD430D5	A quarterly newsletter issued to nurse leader throughout Russia.	Milburn	Sarkisova
LD430D6	Nursing Education Reform Project, Nursing Associations Development Project, All-Russian Nursing Association Development Project.	Milburn	Sarkisova
Moscow Association of Health Insurance Organizations			
LD431D1	Publication of at least five (5) articles on health insurance reform in Moscow magazines or newspaper.	Rice	Budenkov
Foundation for the Development of Health Care Management Training Program			
LD432D1	Two issues of the Foundation Bulletin	Rice	Denisov
Russian Academy of Medical Sciences, Semashko Institute			

Matrix of Russia Grant Products

File Name	Title	Technical Advisor	Counterparts
LD433D1	Five issues of the journal's supplement with articles on critical subjects such as health epidemiology, quality, management, new technologies, medical information science, health insurance, and health reform.	Rice	Ovcharov
Healthy Lifestyle Promotion			
Nizhny Novgorod Alcoholism Treatment Program - "Center of Twelve Steps"			
HL401D1	Document describing steps required to establish private, non-profit clinic, including copies of all legal and regulatory documents that were prepared by or received by the clinic during the process of legal registration.	Hildebrand	Gursky
HL401D4	Final Report/Manual Describing How to Open Up a New Center	Hildebrand	Gursky
Beam of Hope Charitable Association			
HL403D1	Document describing clinic results of prophylactic examination of 300 children, including # children appropriately immunized for their age, # children referred for immunizations, # children treated for ear infections an	Hildebrand	Gubareva
HL403D2	Document describing the methodology used to determine the cost-effectiveness of the routine screening program and the results of the cost-effectiveness analysis.	Hildebrand	Gubareva
HL403D3	Document describing all materials prepared for the seminar attended by Moscow Oblast health officials.	Hildebrand	Gubareva
Izhevsk Mayorate			
HL415D1	Report on community health status	Rice	Zagrebina
HL415D2	Analytical report on the results of sociological survey „Izhevsk citizens' health attitudes".	Rice	Zagrebina

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File Name	Title	Technical Advisor	Counterparts
Kostroma Mayorate			
HL416D2	Collection of videotapes with birth control and sex education materials.	Rice	Babenko
HL416D3	List of methodological and lecture materials	Rice	Babenko
HL416D4	Seminar programs.	Rice	Babenko
HL416D5	Stories for local periodicals.	Rice	Babenko
Lipetsk Mayorate			
HL417D1	Description of the community health and environment status.	Rice	Lee
HL417D2	Articles in newspapers and memos for parents.	Rice	Lee
HL417D3	Immunologist work schedule for children's polyclinics.	Rice	Lee
HL417D4	Schedule of public relations activities.	Rice	Lee
HL417D6	Vaccination check-up schedules for children's polyclinics.	Rice	Lee

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File Name	Title	Technical Advisor	Counterparts
HL417D7	Vaccination coverage records (diphtheria, polio, whooping cough, measles, epidemic parotitis) on 1995 and 1996.	Rice	Lee
HL417D8	Report of the Central State Sanitary and Epidemiology Surveillance on incidence for the above-indicated infections in 1995 and 1996.	Rice	Lee
HL417D9	Software for vaccination needs of children's polyclinics.	Rice	Lee
Russian Charitable Fund "No to Alcoholism and Drug Addiction			
HL422D1	Materials for workshop participants, including plan/schedule for the training period, plans for each workday, timetables, list of participants, resumes of all teachers, abstracts of lectures, survey forms, exhibits, tests, etc.	Rice	Goncharova
HL422D2	Brochure Basics of Management for Health Care Leaders	Rice	Goncharova
HL422D3	Brochure "Theory & Practice of Medical & Social Work in Marcology"	Rice	Goncharova
AESOP Center			
HL429D1	Sexual Health Training Manuals.	Rice	Gardner
HL429D2	Sexual Health Training Brochures.	Rice	Gardner
HL429D3	Five electronic accounts in GlasNet for Coalition members/affiliates.	Rice	Gardner
Efficiency Improvement of In-Patient Care			
Novoaltaisk Hospital			

Matrix of Russia Grant Products

File Name	Title	Technical Advisor	Counterparts
QI304D1	A detailed analytical report describing the current methodology for analyzing and determining hospital bed and labor capacity requirements and utilization and for allocating resources	Sheiman	Litvinenko
QI304D2	A detailed analytical report describing the methodology for determining the expected labor and hospital bed capacity requirements by level and type of non-acute careunder a reorganized in-patient structure	Sheiman	Litvinenko
QI304D3	A report and computer spreadsheet model describing # health facilities, equipment, labor capacity and the hospital bed capacity and utilization in Altai Krai for regional, district and village hospitals.	Sheiman	Litvinenko
QI304D4	A report describing recommendations for: restructuring hospitals to provide an appropriate number of beds and equipment for each level of care, (according to revised standards for clinical requirements).	Sheiman	Litvinenko
QI304D5	A report describing recommendations for: increasing the internal efficiency of the inpatient care sector.	Sheiman	Litvinenko
Dubna Central Municipal Hospital			
QI407D1	Document describing the training program in intensive rehabilitation created by the hospital for intensive care nurses.	Hildebrand	Dmitriev, Makarova, Mukhin
QI407D2	Document summarizing the computer software and system designed to improve the scheduling of physicians and operating room associated with treating myocardial infarct patients.	Hildebrand	Dmitriev, Makarova, Mukhin
QI407D3	Document describing the results of the analysis of the cost of treating and rehabilitating myocardial infarct patients using the previous method and describing the managerial, organizational and personnel changes required to implement the new method.	Hildebrand	Dmitriev, Makarova, Mukhin

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File Name	Title	Technical Advisor	Counterparts
QI407D4	Evaluation of work done by Dubna Hospital	Hildebrand	Dmitriev, Makarova, Mukhin
QI407D5	Critical Issues of Treatment of Chronic Cases of Ischemia Heart Disease	Hildebrand	Dmitriev, Makarova, Mukhin
Stavropol Krai Clinical Hospital			
QI409D1	Report describing procedures implemented to reduce pre-operation length of stay, including procedures to provide timely diagnostic services and to reduce duplication of diagnostic and treatment services.	Makarova	Yakovleva
QI409D2	Report describing the three level quality assurance system implemented in the Krai Hospital and the impact of this system on the quality of care being provided.	Makarova	Yakovleva
QI409D3	Document that contains training materials and all other materials prepared for staff training sessions and for the conference of Krai health workers planned for the end of the grant period.	Makarova	Yakovleva
Central Medical Unit 122, St. Petersburg			
QI411D1	Document describing clinical pathways and standards of care developed for most frequent in-patient and out-patient diagnoses.	Hildebrand	Grigorieva
QI411D2	Document describing clinical procedures and pre-hospitalization and post hospitalization procedures that were transferred from the in-patient to the out-patient setting	Hildebrand	Grigorieva
QI411D3	Document describing procedures that were implemented to increase the continuity of care between the polyclinic and hospital setting and to provide each patient with one physician responsible for coordinating out-patient and in-patient care.	Hildebrand	Grigorieva
QI411D4	Document describing the diagnostic and treatment procedures that were modernized, updated and made more cost-effective and the methods by which these diagnoses and treatments were made more cost-effective.	Hildebrand	Grigorieva

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File Name	Title	Technical Advisor	Counterparts
QI411D5	Document describing the system that was implemented to improve the scheduling of surgical facilities and surgeons.	Hildebrand	Grigorieva
Sverdlovsk Oblast Territorial Fund			
QI414D1	Document describing information needs of territorial fund managers and specifications for all new software developed under grant program.	Woodard	Leontiev
QI414D2	Document describing the territorial fund management decisions that were influenced by the information provided by the new software and the impact of having additional information on the ability to make informed decisions.	Woodard	Leontiev
QI414D3	Document describing the improved decision making capability that resulted from the newly available information.	Woodard	Leontiev
QI414D4	Document describing the training materials and curricula that were used to train territorial fund managers to use newly available information for improved decision making.	Woodard	Leontiev
QI414D5	Document describing the cost-effectiveness analysis of home-based nursing and rehabilitation care and the conclusions.	Woodard	Leontiev
QI414D6	Document describing the personnel and equipment needed to implement home-based nursing and rehabilitation service, the actual services provided, and the organizational and managerial changes made to implement the home-based system.	Woodard	Leontiev
QI414D7	Document describing early discharge of patients with miocardial infarct.	Woodard	Leontiev
Central Clinical Hospital the President's Administrative Department Medical Center			
QI423D1	Maryland Hospital Association (the chapters corresponding to the quality indicators selected for implementation in the Hospital).	Hildebrand	Tarasov

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File Name	Title	Technical Advisor	Counterparts
QI423D2	The Manual on application of quality indicator system of Maryland Hospital Association to Russian hospital practice.	Hildebrand	Tarasov
QI423D3	Selected publications issued during implementation phase.	Hildebrand	Tarasov
QI423D4	Plan for Seminar	Hildebrand	Tarasov
QI423D5	Paper on talk given in Jerusalem	Hildebrand	Tarasov

APPENDIX 9

LIST OF DOCUMENTS INCLUDED ON FIRST CD ROM

Appendix 9: List of documents Included on First CD ROM

Strategics for Implementing Global Budgets - Holahan J., Blumberg L.J., Zucherman S.	How to take care of your baby before birth	Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment. Manning, W., Newhouse, J., Duan, N., Keeler, E., Leibowitz, A., Marquis, S.
Expenditure Limits and Cost Containment. - Ginsburg P.B.	Rx for Pain: Pharmacologic management of low back pain. Stern C., Pharm D.	The Competitive Nature of the Primary-Care Physician Services Market. McCarthy, T. R.
Managing the Health Care System Under a Global Expenditure Limit: A Workshop Summary - Rogal D.L., Gauthier A.K., Barrand N.L.	HIPCs: California health-insurance program a model for the nation? Brydlof C.	Is Medical Care Different? Pauly, M. V.
Shock Treatment for a Sick System - Schear S.	Utilization review. Goldman N.	Directions in Contracting for Psychiatric Services Managed Care Firms. Rodriges, A. R.
Implementing hospitalwide quality assurance - O'Sullivan D. D., Grujic S. D.	Is it time to combine utilization review and admitting? Rode D.	Contract Issues and the Practice of Medicine. Bartoshesky, P. B.
Prevention strategies pay off	Hospital spending in the USA and Canada: A Comparison. Newhouse J., Anderson G., Roos L.	The Total Costs of Illness: A Metric for Health Care Reform. Gustafson, D.
Phone services help control patien demand, reducing unnecessary utilization - Conklin M. S.	Managing the translation to capitation. Kolb D., Horowitz J.	A Primer on Competition in Medical Markets. Pauly, M.V.
Mcos: they like the overall plan, but… - Packer-Tursman J.	A Guide to Establishing Programs for Assessing Outcomes in Clinical Settings. Joint Commission. The Joint Commission on Accreditation of Healthcare Organizations	The Value of Risk-Reducing Information. Woodward, R., Boxerman, S.
Can Managed Care Control Costs? - Moran D.W., Wolfe P.R.	The Medical Outcomes Study. An Application of Methods for Monitoring The Results of Medical Care - Tarlov A. R., Ware J. E., Greenfield S., Nelson E. C., Perrin E., Zubkoff M.	Global Budgets: A Key to Clinton's Reform Strategy? White, J
Integrared systems: subspecialists as capitated primary care physicians? - Vincent D. A.	The computer meets medicine: emergence of a discipline - Blois M. S., Shortliffe E. H.	A Physician Support Model in Managed Care: the Clinical Monitoring Service (SMS). Africh T., Íyatt J., Schwartz M., Spence R., Zimmerman A., Zingo C.
Phisician - hospital integration and direct contracting in manages care programs - Fine A.	A Further Analysis of the Physician Inducement Controversy - Stano M.	Introduction of An Automated Medical Record at an HMO Clinic. Ñhurgin, Peter
Successful Networks will manage indirect health costs for employers - Conklin M.	Quality management in the NHS: the doctor's role -1 - Berwick D., Enthoven A., Bunker J.	Designing Studies of Computer-Based Alerts and Reminders. DAVID M. RIND, M.D., ROGER DAVIS, Sc.d., CHARLES SAFRAN, M.D.
Health Care Reform in the States: Florida; Fresh Thinking for a Spending Squeeze - Findlay S.	Quality management in the NHS: the doctor's role - II - Berwick D., Enthoven A., Bunker J.	A Guide to Mosaic and the World Wide Web for Physicians. W.Paul McKinney, M.D., James M.Wagner, M.D., Glenn Bunton, M.S., And Lynne M. Kirk, M.D.

Lewin shows how MCO, IHS competition will cut costs - Johnson D. E. L.	Assessing the evidence on HMO performance - Luft H. S.	Computer-Generated Patient Handouts (Review). Kahn G.
Market Memo: Blues and hospitals form integrated and collaborative community partnerships - Kania A. J.	Open architecture and integrated information at Columbia-Presbyterian Medical Center - Clayton P. D., Sidili R. V., Sengupta S.	A Quarter-Century of Computer-Based Medical Records. William W. Stead, M.
Is the price right? - Sandberg M.	System Design and Evaluation - Perreault L. E., Wiederhold G.	Systems for the Year 2000: The Case for an Integrated Database. WILLIAM W. STEAD, M.D.
Antitrust policy and real health care reform - Davidson D.	Project management: putting continuous quality improvement theory into practice - Andreoni V., Bilak Y., Bukumira M., Halfer D., Lynch-Stapleton P., Perez C.	Using Information Technology to Fight AIDS. Charles Safran, M.D.
Medical - Record System - McDonald Pharmacy Systems - Speedie S.M. Laboratory Information Systems - Jr. Smith	Financial Risk, Accountability and Outcome Management: Using Data to Manage and Measure Clinical Performance - Rosenstein A.	Trends in Computer Applications in Medical Care. Safran Ch., Gladstone S., Lo E., Boro J., Slack W.
Health level seven - Shortlifse E.H. Department of Services - McGee R. Nursing Information Systems J. Ozbolt	Advanced pricing strategies for hospitals in contracting with managed care organizations -Horowitz J. M., Kleiman M. A.	Pain and Quality Assessment/Improvement. Ferrel B., Whedon M., Rollins B.
A model of capitation.Selden T. M.	The future of computer applications in health care - Fagan L. M., Perreault L. E.	Impact Care: A Quality Assessment Tool That Works. Brotherton G., Babka J.
Estimating Hospital Costs: A MultipleOutput Analysis - Grannemann T. W., Brown R. S., Pauly M. V.	Complying With New TB Guidelines: A Realistic Plan - Sass A., Gregory P., Mayher K., Earnest R., McCallum S., Thoburn S., Balun M., Plamondon M., Kilner J., Anderson G.	A public Policy Framework for Our Nation's Health Information Infrastructure. Larry LaRocco, Congressman
Data Needs of Profiling Systems - Brand D. A., Quam L., Leatherman S.	The transition to medication system performance indicators - Petita A., Kaatz S., Estrada C., Effendi A., Anandan J. V.	HMO Growth and Hospital Express and Use: A Simultaneous - Equation Approach. McLaughlin, Ñ.G.
A method for risk adjusting employer contributions to competing health insurance plans - Robinson J. K., Luft H. S., Gardner L. B., Morrison E. M.	The effectiveness of managed competition in reducing the costs of health insurances - Feldman R., Dowd B.	The Effect of HMOs on Overall Hospital Expenses: Is Anything Left after Correcting for Simultaneity and Selectivity? McLaughlin, C.G.
Information asymmetry and search in the market for physicians' services - Rochaix L.	Reducing Health Care Delivery Costs Using Clinical Path: A Case Study on Improving Hospital Profitability - Clare M., Sargent D., Moxley R., Forthman T.	Direct contracting: Employers look to hospital - physician partnerships to control costs. Johnsson, J.
Impact of Profiles on Medical Practice — Background Paper for Conference on Profiling. Schoenbaum S. C., Murrey K. O.	Practice Policies: Where Do They Come From? - Eddy D.M.	Direct purchase contracts carry risks, benefit. Fine, A.
Medical decision making: probabilistic medical reasoning - Owens K. D., Sox H. C. Jr.	The new risk management. Clark R.	Let's Pull Together... Alcoholism is a family problem. Christmas, R.
What does the demand curve for medical care measure? - Feldman R., Dowd B.	The effect of HMO on premiums in employment-based health plans. Feldman R., Dowd B., Gifford G.	Pelvic Inflammatory Disease (PID). Christmas, R.

Measuring input prices for physicians: the revised medicare economic index - Freeland M. S., Chulis G. S., Arnett R. H., Brown A. P.	Paying Specialists and Subspecialists on a Capitated Basis. DeMuro P.	Prepare now for tomorrow's managed care environment. Tagg, A.J.
The Demand for Episodes of Treatment in the Health Insurance Experiment. - Keller E. B., Rolph J. E.	Planning along the continuum of care. Clark C.S.	Caution required when contracting with managed care organizations. Hirsh, B.D., Wilcox, D.P.
Hospitals seek new ways to integrate health care. - Anderson H. J.	The Relationship Between Medical Resources and Measures of Health: Some Additional Evidence. Newhouse J., Friedlander L.	An integrated approach to managed care contracting. Shapleigh, Ch.
Pricing medical services in the managed care environment - Schroeder R. E., Atkinson A., Armstrong R.	Legal considerations in managed care contracting. Miller W.	Value analysis pinpoints costs. Rifai, A., Pecenka, J.O., Ford, P.J.
Specialty service contracting. -Malcolm C. L., Fukui, M.	Methods of compensating physicians contracting with managed care organizations. Goldfield N., Berman H., Collins A., Cooper R.	Development of physician networks. Krentz, S.E., Hill, J.S.
Successfully managing managed care: Organizational skills needed by hospitals to compete in an era of managed care	Payer and Provider Relationships: The Key To Reshaping Health Care Delivery. Nancy M. Paris, Juanita Hines	Health Maintenance Organizations: The Beginning or the End? Fedlman, R., Kralewski, J. and Dowd, B.
A Bridge to Compromise: Competition Under a Budget	Who Should Govern The Purchasing Cooperative? Zelman W. A.	Determinants of Neonatal Mortality Rates in the U.S. A Reduced Form Model. Corman, H., Grossman, M.
Witness To A Thousand Stories: A Look At Insurance Data. - Gabel J. R.	Delivery of Health Care to the Underserved: Potential Contributions of Telecommunication Technology. MacGee R., Tangalos E. G.	I mind very much if you smoke Christmas, R.
A Single Payer System in Jackson Hole Clothing	Is a single-payer system the answer for the uninsured? Rogers G. T.	Appointment Access: Planning to Benchmark a Complex Issue. Lewis, A.V., White, J., Davis, B.
Tracing the Cycle of Health Insurance.- Gabel J., Formisano R., Lohr B., DiCarlo S.	The History and the Principles of Managed Competition. Enthoven A. C.	Moving beyond generic integration models. Goldstein, D.
State Report. Will Employer Mandates Really Work? Another Look at Hawaii	Building a Legacy for the Future: Creating an Integrated Healrh Care System. King J. G.	How to evaluate managed care contracts. Lewis, J.B.
Southern California Edison's Performance Standards: An employer's Key to Quality Care Delivery	Direct Contracting with employers doesn't need to be complicated. Kraft J.	Reorganizing the Financial Flows in American Health Care. Reinhardt, U.E.
Three's Company: Hospital, physicians and community make a strong alliance	Creating an Integrated Health Care System as a Basis for Managed Care Excellence: A Health Plan's Perspective. Bushick J. B.	Developing a winning strategy for managed care contracting. Johnson, J.
Milwaukee: Three hospital systems lead the way to integration in 'Brew City'	The Volume-Outcome Relationship: Practice-Makes-Perfect or Selective-Referral Patterns? H. S.Luft, S. S.Hunt and S. C.Maerki	Negotiating successful managed care contracts. Clark, B.W.
Designing HIPCs	High-Quality Mammography: Information for Referring Providers	The Role of Managed Care in Integrated Delivery Networks. Jennings, M.C., O'Leary, S.J.

Albuquerque, New Mexico. Systems integration is prelude to development of AHPs	Recovering After a Stroke	Positioning for capitation by redesigning internal processes. Gardner, J.R., Marlney, R.
Direct contracting: hospitals discover its risks and rewards	Clinical Practice Guidelines for Screening, Evaluation and Management of Adult Hypertension.	Factoring in the financials. Court gives nod to economic credentialing: Hudson, T.
Clinical contracting moves into managed careTaylor K. S.	Acute Pain Management: Operative or Medical Procedures and Trauma	Overcoming crack, schizophrenia, and homelessness. A comprehensive case management approach - Dende J., Kline J.
The Regulation of Preferred Provider Arrangements.- Rolph E. S., Ginsburg P. B., Hosek S. D.	Managment of Cataract in Adults	A case Study of Two Health Maintenance Organizations' Experience in Reducing Specialty Cost Through the Development of Two Specialty Risk sharing Programs. DeCuypere M. J., M.H.A.
Clinical cqi. A book of readings - Neuhauser D., McEachern J. E., Headrick L.	Cataract in Adults	Managing a Health Plan's Risk Under Capitation Contracts with Independent Health Care Providers. Katz, P. M., Wheeler, R. C.
Benign Prostatic Hyperplasia:Diagnosis and Treatment.- McConnell J.D., MD (Chair)	Depression Is A Treatable Illness	Do's & Don'ts for Managed Care Contracting. Hendrickson, Susan
Managing Early HIV Infection. - El-Sadr W., MD, MPH (Co-Chair), Oleske J. M. MD, MPH (Co-Chair)	A CONSUMER-CHOICE HEALTH FOR THE 1990s. Universal Health Insurance in a System Designed to Promote Quality and Economy (First of Two Parts) - Enthoven A., Kronick R.	Costs and Benefits of Integrated Healthcare Systems. Coddington, D., Moore, K., Fischer E.
High-Quality Mammography: Information for Referring Providers Bassett L.W.,MD(Co-Chair), Hendrick R.E.,PhD(Co-Chair)	A CONSUMER-CHOICE HEALTH PLAN FOR THE 1990s. Universal Health Insurance in a System Disigned to Promonte Quality and Economy (Second of Two Parts) - Enthoven A., Kronick R.	The Integrated Academic Information Management System at Columbia - Presbyterian Medical Center. Hendrickson, G., Anderson, R.K., Clayton, P.D., Cimino, J., Hripcsak, G.M., Johnson, S.B., McCormack, M., Soumitra Sengupta, Shea, S., Sideli, R. and Roderer,
Pressure Ulcers in Adults: Prediction and Prevention. Bergstrom N.,PhD,RN,FAAN (Chair)	Rate Regulation as a Stragegy for Hospital Cost Control: Evidence from the Last Decade - Sloan F. A.	A New Format for the Medical Record. Bishop, Ch.W.
Pressure Ulcers in Adults: Prediction and Prevention.Bergstrom N.,PhD,RN,FAAN (Chair)	Health Care in America - The Political Economy of Hospitals and Health Insurance - Sloan F. A.	OCIS: 15 Years' Experience With Patient - Centered Computing. Enterline, J.P., Lenhard, R.E., Blum, B.I., Majidi, F.M. and Stuart, G.J.
A Magic Bullet for Managed Care. Lewis A.	The Hospital Service Market: A Disequilibrium Analysis - Hay J.,Anderson G.	Effects of Computer Reminders for Influenza Vaccination on Morbidity During Influenza Epidemics. McDonald, C.J., Hui, S.L. and Tierney, W.M.
Design of Health Insurance Purchasing Cooperatives. Starr P.	Do health maintence organisation work for Medicare? - Brown R., Clement O., Hill J., Reychin S., Bergeron J.	Exploring the Internet. Zelingner, J.
Data Watch: Satisfaction with Health System in Ten Nations. Blendon R., Leitman R., Morrison I., Donelan K.	Self-funded benefits plans enjoy freedom and flexibility - Grobman M	Potential Identifiability and Preventability of Adverse Events Using Information Systems. Bates, D.W., O'Neil, A.C., Boyle, D., Teich, I., Chertow, G.M., Komaroff, A.L., Brennan, T.A.

Disease Management: Continuous Health-Care Improvement. Terry K.	Strategies for lowering health care costs - Meyer J.	Hospital Information Systems. Wiederhold, G., Perreault, L.E.
Small HMO Embraces Disease State Management	Things To Know About Quality Mammograms	Guide to Quality Assurance. The Joint Commission
Will Drug Companies Play a Role? Terry K.	Recovering From Heart Problems Through Cardiac Rehabilitation	Antitrust Enforcement: Putting the Consumer First. Metzenbaum, Howard M.
Hospital managed care performance standards. Sister Peck T.,Schopp D., Foshage	Using Strategic Planning To Managed Care Growth. Horowitz H.	Running With the Herd: Building a Business Strategy. Beckham, Daniel
Disease Management: At These Companies, The Future is Now. Terry K.	Clinical Practice Guidelines for Adult Cholesterol Management	Setting Payment Rates for Capitated Systems: A Comparison of Various Alternatives. Anderson, Gerard; Steinberg, Earl; Powe, Neil; Antebi, Shlomi; Whittle, Jeffrey; Horn, Susan; Herbert, Robert
The Age of Social Transformation. Drucker P.	Protection of Confidentiality in the Computer-Based Patient Record. Safran, Charles; Rind, David; Citroen, Mieke; Bakker, Albert; Slack, Warner; Bleich, Howard	Vertical Integration Models to Prepare Health Systems for Capitation. Cave, D.
Making managed care work for you: Tips on setting up a cost-effective practice. Shapiro E., Blyweiss D.	A Computer-Based Outpatient Medical Record for a Teaching Hospital. Safran, Ch., Rury, Ch., Rind, D. M., Taylor, W. C.	Alternative Delivery Systems and Medicare. Ginsbur, Paul; Hackbarth, Glenn
Your Care Path. A Daily Guide to Recovery From Pneumonia. Methodist Medical Center	The Medical Record: Problem or Solution? Esterhay, R. J.	Antitrust, Competition and Health Care Reform. Bloch, Robert E.; Falk, Donald M.
Preferred Provider Organizations:Performance, Problems and Promise. Gabel J., Ermann D.	Herpes. STD Education Unit	An Iconoclastic View of Health Cost Containment. Newhouse, Joseph P.
Disease State Management: Identifying an Rx for Savings.	The Help System: A Review of Clinical Applications in Infections Diseases and Antibiotic Use. Evans, R.S.	Managed Care Is More Than Cost Containment. Simpson, Rory
Clearing the Air: How To Quit Smoking...and Quit for Keeps.	Physician to Physician Manager: Training for a Smooth Transition. Buchanan, P.; Matchett, W.; Miller-Phipps, J.; Muchnic, P.; Radin, R.; Tillman, J.	How Pacific Telesis put health care costs on hold. Noda, Bruce; Austin, Nell
Arthritis education: opportunities and state of the art. Daltroy L. H., Liang M. H.	Epidemiologic Approaches to Quality Assessment. Simmons, B.P., Kritchevsky, S.B.	Don't get squeezed by a managed-care contract. Holoweiko, Mark
The efficacy of preparation for surgery and invasive medical procedures. O'Halloran C. M., Almaier E. M.	SHEA-CDC TB Survey, Part I: Status of TB Infection Control Programs at Member Hospitals, 1989-1992 Fridkin, S.K., Manangan, L., Bolyard, E., Jarvis, W.R.	Tearing Down the Myths. Novoselski, D.
Practice guidelines and reminders to reduce duration of hospital stay for patients with chest pain. Weingarten S. R., Riedinger M. S., Conner L., Lee T. H., Hoffman I., Johnson B., Ellrodt A. G.	Health Status of Populations as a Measure of Health System Performance. Zajac, Barry, Green-Weir, Robby, Nerenz, David	Employers negotiate with hospital group. Frieden, Joyce

Nosocomial pneumonia and mortality among patients in intensive care units. Fagon J.-Y., Chastre J., Vuagnat A., Trouillet J.-L., Novara A., Gibert C.	Managed Care and the Treatment of Asthma Review Article. O'Brien K.	Managed Care Organizations. Shoor, R.
Do physicians induce demand for medical servises? Rice T., Labelle R.	Changing Physician Behavior to Improve Disease Prevention. Cohen S., Halvorson H., Gosselink C.	Do any-willing-provider laws really help doctors? Pretzer, Michael
Where Are We In Tuberculosis Infection Control? Tapper M.	A Cost-Effectiveness Analysis of Acute Care Case Menagement Outcomes. Allred, C., Arford, P., Michel, Y., Dring, R., Carter, V., Veitch I.	Communication Strategies to Improve Drug Use Evaluation Saine, D.

APPENDIX 10

COMPARISON OF NUMBER OF COPIES OF ZDRAVREFORM DOCUMENTS TO BE PRINTED FOR DISSEMINATION UNDER DIFFERING SCENARIOS

Appendix 10: Comparison of Number of Copies of ZdravReform Documents to be Printed for Dissemination Under Differing Scenarios

Code #	Product Name	Original Number of Copies Proposed	Recommen-dations by Russian Health Experts	Reduced Number of Copies in 1st B&F	Scenario 1 Final Negotiations: Number of Copies	Scenario 2: Final Negotiations: Number of Copies
Technical Products						
MMN002	Practical Guidelines for Contract Development and Implementation in Health Care	2,000	2,000	1,000	1,000	1,000
MMN003	Development of General Practices in Polyclinics (Tomsk working model)-methodological recommendations	2,000	2,000	1,000	1,000	1,000
MMN003A	Development of GPs in MHI Enviroment (Methodological Recommendations), Tomsk	1,500	1,500	1,000	1,000	1,000
MMN004	Development of General Practices in/near Polyclinics - manual, Kemerovo	2,000	2,000	1,000	1,000	1,000
MMN005	Hospital Cost Accounting	3,000	3,000	1,000	1,000	1,000
MMN005A	Hospital Case-Mix System Development	2,000	2,000	1,000	1,000	1,000
MMN006	Utilization Management	3,000	3,000	1,000	1,000	1,000
MCS001	Cost Benefit Analysis	2,000	2,000	1,000	1,000	1,000
MCS004	Manual on Financial Modeling	2,000	2,000	1,000	1,000	1,000
MPP006	Restructuring Polyclinics in E. Germany, Implications for Russia	2,000	2,000	1,000	1,000	1,000
PMN001	Manual 1	3,000	3,000	0	0	0
PMN002	Manual 2	3,000	3,000	0	0	0
PMN003	Manual 3	3,000	3,000	0	0	0
FMN002	HMO Manual for Russia	2,000	2,000	1,000	1,000	1,000
FMN003	Outpatient Payment Methods (Kemerovo)	1,000	1,000	1,000	1,000	1,000
FMN005	Costing Medical Benefit Packages	500	500	500	500	500
FCS001	Global Budgets for Hospitals (British Model)	2,000	2,000	1,000	1,000	1,000
FCS002	New Payment Methods for Hospitals (Tomsk working model)	1,000	1,000	1,000	1,000	1,000
QMN001	Manual on Quality	3,000	1,000	1,000	1,000	1,000
IMN003	Health Insurance Beneficiary System (Kemerovo)	100	100	100	100	0
IMN004	Clinical Patient Record System (HMO and Polyclinic) (Kemerovo, Barnaul)	1,000	1,000	1,000	1,000	1,000

GRANT PRODUCTS						
LD421D2	Course On Healthcare Quality Evaluation	1,000	500	1,000	500	500
LD421D3	Course On Social Off-Budget Funds	500	0 or 100	500	0	0
LD421D4	14 Documents on Healthcare Finance translated from English (each approx. 10-30 pages)	1,000	NA	1,000	0	0
LD426D2	Book on Health Economics	1,000	500	1,000	500	500
LD426D5	Book on Statistics in Healthcare	1,000	1,000	1,000	1,000	1,000
LD426D6	Book on Mandatory Health Insurance	1,000	500	1,000	500	500
LD426D7	Book on Personnel Management	500	1,000	500	500	500
LD426D10	Book on Voluntary Medical Insurance	500	500	500	500	500
LD426D11	Book on Health Management and Marketing	1,000	500	1,000	500	500
LD426D12	Book on Healthcare Structure Organization	500	500	500	500	500
LD427D6	General Document on Quality of Health Services, meant for new healthcare leaders or administrators	500	100	500	100	0
LD427D7	Lectures on Healthcare Information Systems (around 20 lectures, each 5-10 pages)	500	100	500	100	0
LD427D9	Work Program and Lectures on Sociology and Psychology of Management (Write document, needs formatting)	1,000	100	1,000	100	0
PM302D1	Document Describing Payment Methods Based on the DRG System	500	500	500	500	500
QI411D6	Improvement of Economic Effectiveness for Outpatient Care	500	500	500	500	500
QI414D8	New Sverdlovsk Document	500	100	500	100	0
QI423D1	Document Describing How Quality Indicator of the Maryland Hospital Were Implemented in a Russian Hospital	1,000	500	1,000	500	500
Totals		53,600	46,000	29,100	23,000	22,500

APPENDIX 11

LIST OF DOCUMENTS DISSEMINATED AT ALL RUSSIA CONFERENCE

Appendix 11: Electronic and Hard Copy Documents Disseminated at All Russia Conference, November 21-24, 1996

Title	Authors	Title	Authors
Electonic Copies		**Hard Copies**	
Contracting. Contract Forms. Practical Guidelines.	S.A. Banin	Integrated Health Insurance Models. Manual. Moscow-Kemerovo 1996.	
General Physician Practices: Methods of Organization. Practical Guidelines.	V.F. Oleinichenko/ others	Structure of GP Practices. Practical Guidelines. Moscow-Tomsk 1996.	
Phased Restructuring of Outpatient Care. Transition to General Physician Practice under Health Insurance Framework. Practical Guidelines.	S.A. Banin	Development and Implementing of thormylary at Health Facilities. Practical Guidelines. Efficient Pharm.Management Project for Russia. 1st Ed. 1996.	
Establishment of General Physician Practices. Manual.	L.A. Sedacheva	Implementing the Drug Evaluation Program at Health Facilities. Practical Guidelines. Efficient Pharmaceutical Management Project for Russia. Washington- Moscow 1996.	
Utilization Management. Practical Guidelines.	Henry Leavitt	International Physician Practice Magazine, 1, 1996.	
Improving the Performance of Health Financial Agents. Discussion Papers.	James A. Rice	Improving Health Care Management in Central and East Europe. Collection of works with Dr. James A. Rice as General Editor.	James A. Rice
Approaches to the Development of the Integrated Health Care Delivery and Financial Modeling.	I.M. Sheiman	Mixed Economy Model in Health Care.	James A. Rice.
Rate Setting under Health Care Reform.	T.N. Makarova	Contracting. Contract Forms. Moscow-Tomsk 1996.	
Restructuring Polyclinics into Freestanding General Practices in East Germany. Relevance for Russia.	I.M. Sheiman	Development and Use of New Policlinic Payment Methods. Moscow-Kemerovo 1996.	
Integrated Health Insurance Models. Manual.	N.V. Nelepina/ others	Establishment of General Physician Practices. Manual. Moscow-Kemerovo 1996.	
Development and Use of New Policlinic Payment Methods. Manual.	A.I. Zakirov/ others	DRG: Building. Rate Setting and Restructuring. Practical Guidelines. Moscow-Tomsk 1996.	
Basic and Territorial MM Programs: Development and Feasibility Studies. Manl.	E.X. Freed / others	Pharmacy Magazine, 2, 1996.	
Practical Lessons of Implementing the New System.	T.I. Gabdrahimova / others	Phased Restructuring of Outpatient Care. Transition to General Physician Practice under Health Insurance Framework. Practical Guidelines. Moscow-Tomsk 1996.	
Integrated Cost Accounting and Evaluation Model for Inpatient Care. Practical Guidelines.	A.V. Telvukov.	Basic and Territorial NE Programs: Development and Feasibility Studies. Manual. Moscow-Barnaul 1996.	
Excel 5.0. Spreadsheets for the Inpatient Care Cost Accounting and Evaluation Model.		Improving Clinical Quality Assurance under Health Care Reform in Russia. Practical Guidelines.	Stanley J. Tillinghast.
DRG Building. Rate Setting and Restructuring. Practical Guidelines.	A.V. Telyukov	Our Health. AIHA Magazine, 2, 1996.	
Implementing the Drug Evaluation Program at Health Facilities. Practical Guidelines.	Thomas More, Alexander Byakov, Anthony Savelly, Andrey Zagorsky	Issues of Social Hygiene and History of Health Care Magazine.	
Development and Implementing of thormylary at Health Facilities. Practical Guidelines.		Insert into the Issues of Social Hygiene and History of Health Care Magazine. 1-3, 1996.	

Efficient Pharmaceutical Management Project. Summary and Implementing Steps.		Collection of publication Practika Publishing House.	
		Collection of publication Geotar Publishing House.	
		Collection of publication Mediasfera Publishing House.	

Zdrav*Reform*
Russia
Grant Appendices to Final Report to USAID Moscow

GRANT APPENDICES

APPENDIX G1: PROFILE OF GRANTEES

APPENDIX G2: MAJOR ACCOMPLISHMENTS

APPENDIX G3 : MANAGEMENT PROCEDURES

APPENDIX G4: STANDARD DOCUMENTS CREATED

APPENDIX G5: DESCRIPTION OF COMPETITION PROCEDURES AND SELECTION CRITERIA

APPENDIX G6: ESTABLISHING A NEW GRANT

APPENDIX G7: PRE-AWARD AUDIT AND ASSESSMENT

APPENDIX G8: SUMMARY OF REPORTS AND PROCEDURES GIVEN TO GRANTEES AFTER CONTRACT SIGNING

APPENDIX G9: PROCEDURAL GUIDE FOR ORGANIZING STUDY TOURS

APPENDIX G1

PROFILE OF GRANTEES

Appendix G1: Profile of Grantees

Establishment of Free-Standing General Practices

30.001 ASOPO-Zhizn Insurance Company
$50,000
Address: 630104, Novosibirsk, 65 Krasni Prospect
Contact: Alla Ivaninskaya
Tel: (3832) 667478, fax: (3832) 665023

ASOPO-Zhizn has established private family practices within three government polyclinics in the Novosibirsk region. The grantee also worked with the local administration to develop policies and the legal framework to adapt private practices into the Russian health care system.

Key deliverables:
1. Document that outlines the job descriptions, roles and responsibilities of the private physicians and their assistants.
2. Contract for renting GP office space.
3. Document that describes the legal, policy and administrative changes that were needed to establish the private practices.
4. Document summarizing in detail the private practices' office budgets, estimates of physician productivity, the methodology for calculating capitated payments and the level of capitated payments made to physicians.

30.003 Altai Krai Health Care Committee
$71,200
Contact: Valery Elikomov
Tel: (3852) 231601

The Altai Krai Health Care Committee has established two free-standing general health practices. The grant objectives included developing a conceptual framework for free-standing general practices within polyclinics and identifying the legal, organizational and financial reforms required to open these free-standing general practices. The grantee has plans to open three additional free-standing general health practices.

Key deliverables:
1. Report describing:
   - The need for and the conceptual framework for restructuring polyclinics
   - The constraints to restructuring that exist in the current legislation.
2. Draft legislation and regulatory documents in Russian, approved by local government authorities, permitting the formation of free-standing primary care practices staffed by self managed family practice physicians.
3. Standard contracts to govern the working relationships between the free standing practice and the polyclinic.
4. Standard contract between GP and 3rd party payer.
5. Document describing procedures for open enrollment, quality assurance and for licensing and accreditation of general practitioners.
6. Document describing training curricula for nurses.

400 Tula-Albany Health Care Insurance Company
$99,900
Address: 300041, Tula, Krasnoarmeisky Proyezd, 7
Contact: Mikhail Tubinshlak
Tel: (0872) 369828 or 369850, fax: (0872) 366584

The grantee has established a non-for-profit organization that can provide an integrated set of in-patient and out-patient services and provide insurance to cover the costs of these services. The grant recipients will provide integrated services to a defined population based on the staff model HMO concept of managed care.

Key deliverables:
1. Document describing the regulatory acts on setting up an HMO.
2. Document describing the business plan.
3. Document with examples of actual contracts with hospitals and with facilities providing specialty care (e.g. psychiatric, maternity and tuberculosis care).
4. Detailed specifications for an information system to support delivery of health services under a managed care model and copy of functioning software.

404 MedExpress Insurance Company
$43,300
Address: 191028, St. Petersburg, 2 M. Konushennaya
Contact: Natalya Shymilova
Tel: (812) 2757801, fax: (812) 2758895

MedExpress Insurance Company has opened a general practitioner's office in St. Petersburg within the mandatory medical insurance system. Patients have the right to choose their out-patient polyclinic, and then within that polyclinic, choose between the general practitioners and the usual polyclinic staff.

Key deliverables:
1. Document describing strategies used by general practitioners to reduce the rate of hospitalization among their patients.
2. Document describing the incentive system used by the insurance company to reduce the rate of hospitalization among patients of the general practice.
3. Document describing all legal and regulatory steps taken to license general practice and to implement new quality control and incentive payment systems, including references to all laws cited as a legal basis for these steps.

Development of New Payment Methods

30.002 Kemerovo Institute of Social and Economic Problems of Health Care
$58,400
Address: 650036, Kemerovo, 43 Volgogradskaya St.
Contact: Galina Tzarik
Tel: (3842) 551983

Galina Tsarik, director of the institute, together with a team of researchers and analysts, has devised an out-patient classification and payment system for Kemerovo out-patient care facilities, based on the DRG method of classification.

Key deliverables:
1. Report summarizing international experience in using DRG-based systems to pay for out-patient care and recommended methods for developing a DRG-based system for use in Russia.
2. Medical Economic Standard Tables.

30.005 Tomsk Health Care Committee
$45,400
Address: 634032, Tomsk, Prospect Lenina, 111, Tomsk Oblast Administration
Contact: Tatiana Gabdrahimova
Tel: (3832) 224740

The Tomsk Health Care Committee addressed cost issues associated with in-patient care. The project recommended new, performance-based methods of paying for in-patient care and field tested these new methods in two hospitals in Tomsk. The project also developed regulations and procedures which will permit and support the implementation of the new payment methods.

Key deliverables:

1. A document detailing a new approach and method for costing hospital care
2. A document describing:
   - Alternative methodologies for making payments to different types of hospitals,
   - Recommended strategies for implementing alternative payment methodologies, and
   - Recommended approaches to setting universal versus hospital-specific rates.
3. A manual describing methodologies for adjusting hospital rates to the amounts paid for medical benefits provided under the Territorial Program of MHI.
4. A report describing the development of performance-based systems of prospective payments and the development of grouping methodologies for several high volume cases.
5. A test of a new payment methods in pilot hospitals and a document describing the protocol for the field test and the results of that test.
6. A document describing principles and methods of contracting with hospitals.

402 LangMedService Insurance Company
$57,677
Address: 626449, Langepas, a/ya 3-4 “a” Mira St.
Contact: Anatoly Mirovsky
Tel: (34669) 25097, fax (34669) 25097

LangMedService provides health insurance for LukOil employees in Langepas. Through the grant, staff were trained and an infrastructure was developed to allow the company to offer mandatory health insurance. Because work under this grant was not completed, deliverables were not provided.

408 Vladivostok Municipal Hospital No. 2
$50,000
Address: 690105, Vladivostok, 57 Russkaya St.
Contact: V. Karepin
Tel: (4232) 213770, fax: (4232) 464686

Under this grant, a hospital based management and information system has been designed and implemented for cost accounting and managing financial transactions within the hospital and between the hospital and insurance companies.

Key deliverable is:

1. Technical training document that describes cost accounting, cost allocation and invoicing procedures adopted by the hospital to improve the hospital's ability to function under a system of health insurance financing.

434 Kaluga Mandatory Health Insurance Fund
$95,000
Address: 248600, Kaluga, Teatralnaya Str., 41/8
Contact: Vladimir Nikolaevich Omelchenko
Tel:(0842) 124 540, fax: (0842) 124 538

The Kaluga MHIF has developed working pilot projects in which Russian and American health care leaders demonstrate the value of reforms for a) quality of care, b) new payment methods for hospitals, polyclinics, and physicians that have incentives for consumer choice and improved provider performance; and c) new health management information systems services delivery and/or health care financing. The MHI has developed at the oblast level, legal and regulatory policies that encourage reasonable reforms and/or remove current barriers to such needed reforms. They have developed technical assistance, education and training opportunities that enhance the knowledge skills and attitudes of Oblast managers working in service delivery and health care financing organizations.

Key deliverables:
1. Description of New Payment Methods.
2. Description of Analytic Tools developed which may include Financial/Demand Modeling, Cost Accounting Methods, Utilization Management, Refining Case-Mix Measures, Clinical Care Mapping.
3. Description of Quality Indicators.
4. Copies of Model Contracts developed for payer, facilities, and staff.

435 Tver Oblast Mandatory Health Insurance Fund
$95,000
Address: 170000, Tver, Volodarskovo Str., 24
Contact: Alexander Nikolaevich Zlobin
Tel:(08222) 551463, 551401

The Tver Oblast MHIF, like the Kaluga MHI, has developed working pilot projects in which Russian and American health care leaders demonstrate the value of reforms for a) quality of care, b) new payment methods for hospitals, polyclinics, and physicians that have incentives for consumer choice and improved provider performance; and c) new health management information systems services delivery and/or health care financing. The MHI has introduced at the oblast level, legal and regulatory policies that encourage reasonable reforms and/or remove current barriers to such needed reforms. They have developed technical assistance, education and training opportunities that enhance the knowledge skills and attitudes of Oblast managers working in service delivery and health care financing organizations.

Key deliverables:
1. Documentation of Terms of Reference for Creation of Councils for Quality Improvement.
2. Descriptions of Quality Improvement Approaches and Indicators for Hospitals.
3. Final analytical report " First Outputs, the Main Trends and Further Development of the Reform Program."

436 Cherepanovo District Hospital and Novosibirsk Oblast MHIF
$50,000
Address: Cherepanovo, Sovetskaya Str., 70
Contact: V.B. Filatov, A. V. Reshetnikov
Tel/Fax: (38345) 2 11 67

The Cherepanovo District Hospital serves as the focal point for a collective effort by the Territorial Fund and the Health Care Committee of Novosibirsk Oblast, the World Bank and the ZdravReform Project to restructure a rural health care delivery and financial system. Through the grant, a cost accounting system has been create. This project has provide baseline information for creating an integrated financial system - the first step in restructuring the health financing system in the rural Cherepanovo Rayon.

Key deliverable is:
1. Cost Accounting System document.
2. Financial Scheme document

437 The Tula Territorial Fund of Mandatory Health Insurance
$25,000
Address: 300041, Tula, Souznaya Str., 1
Contact: Mikhail Nikolaevich Tubinshlak
Tel/Fax:(8312) 33 69 67

The Tula MHI Fund has developed a system of reform in the methods of payment to health care providers. The grant program is based on the Health Support Organization (HMO) which was set up for the citizens of the Sovietsky District of the city of Tula by the non-profit health insurance company Tula-Albany jointly with the 1st City Hospital. The Territorial Fund has enhanced outpatient and hospital care payment methods through contractual relations between

the various structural divisions of the HMO (as well as outside providers), and stimulation of competition between them.

Key deliverables:
1. Charter, Agreement, Decision from City/Oblast for creation of new polyclinic.
2. Contracts between 1) HMO and primary health care physicians, 2) HMO and hospital, 3) HMO and other hospitals with which services have been contracted.
3. Payment Tracking Software.

Dissemination and Leadership Development

418 Saint Petersburg Medical Academy
$50,000
Address: 193015, St. Petersburg, Saltikova-Shedrina St. 41
Contact: Vladimir Nikolaevich Filatov
Tel: (812) 1834427 (w), fax 2751922
E-mail: mapo@maps.spb.su

The Saint Petersburg Medical Academy has developed innovative training programs for Russian managers in the areas of financial planning and management, human health care management, new methods of medical insurance, and medical market research.

Key deliverables:
1. A graduate syllabus for health facility leaders related to the fundamentals of economics, market economy relations in health care, health insurance organization, and entrepreneurship basics.
2. A graduate syllabus for health facility leaders related to modern economic analysis and optimizing the health facility economic performance.
3. A graduate syllabus for health facility leaders related to modern methods of health care management and marketing.
4. A manual on statistical and economic analysis to provide for rationalizing the economic and clinical performance of health facilities.
5. A chapter on application of health management data processing software
6. A manual on risk management at health facility.
7. A manual on the basics of management at health facility.

419 Regional Fund of Compulsory Medical Insurance, Rostov Oblast
$55,000
Address: Rostov-on-Don
Contact: Dmitry Evdokimov
Tel: (8632) 669142, 624877, fax (8632) 624877
E-mail: root@rst.rofoms.rnd.su

Under the grant, the Fund has trained health care leaders to better manage and improve the quality of the health care system in a market economy. Educational materials were also published and distributed to improve the level of expertise within the health care sector in the Rostov region.

Key deliverables:
1. Documents on the results of consultations with experts on developing curricula for training managers of independent quality evaluation.
2. Materials of orientation workshop of health care managers of Rostov oblast.
3. Curricula for training managers of medical and economic evaluation of quality of health care.
4. Training schedule and report on the results of pilot training of health care quality managers for non-departmental expert committee of Rostov oblast.
5. Draft of business plan for establishing regular courses in health care quality management.

6. Draft of the "Provision on Independent Expert Evaluation of Quality of Health Care in Rostov Oblast."
7. Quality control-related materials published in mass media.
8. Description of quality control in medical facilities in Rostov.

420 Association of Don Physicians
$50,000
Address: 346740, Rostovskaya obl., Azov, Inzenskaya St., 3A Apt. 3
Contact: Igor Simakov
Tel: (86342) 31822; fax (86342) 31822
E-mail: glas.adp@apc.org

The Association is a local branch of the federal Association of Russian Physicians. The Association used the grant to publish and distribute the monthly "Don Physicians Newsletter." In addition to the newsletter, the Association created and is maintaining a database of physicians and health care professionals in the Rostov region.

Key deliverables:
1. Six issues of the newsletter.
2. Data base of newsletter recipients.
3. Data base of health care professionals and organizations in Rostov region.
4. Action plan for creation of federal physicians newsletter.

421 Regional Educational-Methodological Center of the Far Eastern Medical Association
$65,000
Address: 680030, Khabarovsk, 57 Lenina St.
Contact: N. Kapitonenko
Tel: 224792, 224821

The Far East Regional Educational-Methodological Center was founded by the Far East Medical Association, Khabarovsk Medical Institute, and the Krai Fund of Mandatory Medical Insurance. The center has published curricula and is providing continuing education courses in the field of health sector management and insurance management in the Far East. They are improving the qualifications of health care managers as they implement reforms throughout the region.

Key deliverables:
The following documents are planned for publication under the grant program:
1. Methodological brochures and manuals for students and trainees
   - Economics and Health Insurance Organizations,
   - Health Care Quality Evaluation, and
   - Social off-Budget Funds,
2. Healthcare Newsletters (3 issues).
3. Materials for workshops and conferences.
4. Financial Problems of Healthcare Reform, and the Development of Medical Insurance System on the Regional Level.

424 Leadership Training Center Under "MedSocEconInform" Public Health Institute
$54,990
Address: 127254, Moscow, Dobrolubova St. 11
Contact: Alexander Miasoedov
Tel: (095) 2193840, fax: (095) 2189098

The research organization "Medical-Social Research, Economics and Informatics" is the leading institution studying medical-demographic processes, conducting scientific-methodological research and structuring health reform in the Russian Federation. They have created a training program for health care professionals. The courses have increased professional knowledge and skills in the areas of health economy, strategic planning, medical marketing, contemporary medical and leadership information systems, and quality of care.

Key deliverables:

1. Descriptions of grant program implementation process in the magazine Zdravookhraneniye Rossiyskoy Federatsii (Health Care of the Russian Federation). Presentations were also made at the collegium if the Ministry of Health and Medical Industry and field meetings of regional health leaders.
2. Publication on experience gained in leadership training.

425 Academy of National Economy Under the Government of Russian Federation, Business Management Center, Institute for Senior Executives
$70,000
Address: 117571, Vernadskogo Prospect 82, 1 Cor., Rm. 335
Contact: Evgeny Mozharov
Tel: 4347500, fax: 4343216

The Academy of National Economy under the Government of the Russian Federation is a state educational establishment dedicated to upgrading and retraining managerial personnel and specialists.
The grant has funded the establishment of a management training program for chief physicians of medical establishments.

Key deliverables:
1. 20-min. educational video on the health leader upgrading program.
2. Upgrading outcomes reports for Groups 1,2,3.
3. Manuals displayed at the international exhibition "World Business School '96".

426 Siberian Fund of Management Development
$65,000
Address: 650070, Kemerovo, Tukhachevskogo St., 33
Contact: Ludmila Isakova
Tel: (3842) 550780, fax: 550610
E-mail: puma@ivczdr.kemerovo.su

The Siberian Fund of Management Development was created to establish a continuing education and certificate program in the area of health maintenance and insurance. The Fund is running a two-year specialized training course entitled "Management in Health Maintenance and in Health Insurance" and is conducting short-term seminars and certificate programs.

Key deliverables:
1. Methodological manual "Mandatory Medical Insurance."
2. Methodological manual "Health Economics."
3. Methodological manual "Statistics in Health and Medical Insurance."
4. Methodological manual "Medical Insurance."
5. Methodological manual "Personnel Management."
6. Methodological manual "Health Management and Marketing."
7. Methodological manual "Health Organization."

427 Novosibirsk State Academy of Economy and Management
$65,000
Address: 630016, Novosibirsk, Kamanskaya St., 56
Contact: Yuri Vasilievich Gusev
Tel: (3832) 247865, fax: (3832) 245910

The Academy provides higher professional education and training, and this grant has funded a new management training program for health care professionals.

Key deliverables:
1. Strategic management, and planning. *(programs, methodological recommendations for test work,)*
2. Health care organization. *(work program only)*
3. Health care management. *(work program, lectures)*

4. Financial management in health care. *(work program, tests)*
5. Marketing of health services. *(work program , tests)*
6. Quality of health services. *(work program , tests)*
7. Information systems in health care. *(work program , tests)*
8. Regional management of health care. *(work program , tests)*
9. Sociology and psychology of management. *(work program, lectures, tests)*
10. Strategy design, comparison of business plan and budget. *(methodological instructions on how to develop a course)*

430 All-Russia Nurses Association
$75,000
Address: 194291, St. Petersburg, Lunacharskogo Prospect, 47
Contact: Valentina Sarkisova
Tel: (812) 3102215

The All-Russia Nurses Association has gained acknowledgment as the umbrella organization for
the fourteen nursing associations existing in Russia, and as integrating entity at the federal level. Yet, the ARNA's efforts are hampered by its communication insufficiencies and infancy status. This project has helped to develop a strengthened and sustainable ARNA so that it will advocate for the needs of practicing nurses, speak on behalf of nurses on issues of health care policy, serve as clearinghouse of information on nursing.

Key deliverables:
1. Working papers that detail the following:
   - the bylaws of the ARNA including the philosophy and goals;
   - the organizational structure including its working groups and their subgroups;
   - the embodiment of the nursing organizations in Russia within the ARNA;
2. *Creation of nursing standards and job descriptions for nurses of* the Russian Federation done in cooperation with the Ministry of Health.
3. *A quarterly newsletter* issued to nurse leader throughout Russia.

431 Moscow Association of Health Insurance Organizations
$60,000
Address: 113152, Moscow, Zagarodnoe Shosse, 18A
Contact: Inna Shelepneva, Vadim Budenkov
Tel: (095) 9586049

The Moscow Association of Health Insurance Organizations (MAHIO) is a voluntary association of health insurance organizations of the Moscow Region. Under the grant, MAHIO has published articles on timely subjects in the journal *Health Insurance*, the newspaper *Medical Courier*, and in general interest papers.

Key deliverables:
1. Publication of five articles on health insurance reform in Moscow magazines and newspaper.

432 Foundation for the Development of Health Care Management Training Program
$ 80,000
Address: 119041, Moscow, Zubovsky boul., 37/1
Contact: Elena Bourganskaya, 3d floor, Room 318

In September 1994 several higher educational establishments united to create the Russian Association of Health Care Management Training Programs. The project helped to strengthen the organizational basis necessary for the development of educational health care management programs, specifically by establishing an organization to develop training programs in modern health care management methods, publishing educational materials, and facilitating communication between various health care management programs.

Key deliverables:
1. Two issues of the Foundation Bulletin

433 Russian Academy of Medical Sciences, Semashko Institute
$ 37,550
Address: 103064, Moscow, Vorontsovo Pole St, 12
Contact: V. Ovcharov
Tel: 9174886, fax: 9160398

The Semashko Scientific-Research Institute of Social Hygiene, Economy and Management of Public Health of the Russian Academy of Medical Sciences has published five special supplements on current health issues in the journal, *The Problems of Social Hygiene and the History of Medicine.*

Key deliverables:
1. Five issues of the journal's supplement with articles on critical subjects such as health epidemiology, quality, management, new technologies, medical information science, health insurance, and health reform.

Healthy Lifestyle Promotion

401 Nizhny Novgorod Alcoholism Treatment Program - "Center of Twelve Steps"
$32,312
Address: Nizhny Novgorod, 2/5 Erevanskaya, Apt. 76
Contact: Victor Gursky
Tel: (8312) 336967, fax (8312) 336967

Victor Gursky, director of the project, has established a new alcoholism treatment center in Nizhny Novgorod based on the "Disease Model Concept" and the Alcoholics Anonymous model, models which are operating successfully in Moscow.

Key deliverable is:
1. Document describing steps required to establish private, non-profit clinic, including copies of all legal and regulatory documents that were prepared by or received by the clinic during the process of legal registration.

403 Beam of Hope Charitable Association
$23,000
Address: 113208, Moscow, 2/15 Sumskoi Per., Apt. 123
Contact: Julia V. Gubareva
Tel: (095) 3110501, 3126887

Beam of Hope Charitable Association has helped to demonstrate the cost-effectiveness of routinely screening children for required immunizations and existing inner ear problems and infections and of providing required services on a timely basis. The staff has examined and screened 300 children who are disabled or orphaned or living in multi-children and incomplete families, collected the data needed for the cost-effectiveness report, cared for the children who are in need of treatment, and presented the findings of the cost-effectiveness report at a workshop.

Key deliverables:
1. Document describing clinic results of prophylactic examination of 300 children, including the number of children appropriately immunized for their age, the number of children referred for immunizations, the number of children treated for ear infections and the number of children hospitalized for ear infections.
2. Document describing the methodology used to determine the cost-effectiveness of the routine screening program and the results of the cost-effectiveness analysis.
3. Document describing all materials prepared for the seminar attended by Moscow Oblast health officials.

405 St Petersburg Mayorate
$99,840
Address: St. Petersburg, 1 Malaya Sadovaya St.
Contact: Gerry MacCarthy
Tel: (812) 3113406, 3114185, fax: 2108538

The grant funded a wide-reaching multi-media health promotion campaign which provided the population of St. Petersburg with basic information on personal health, disease and outbreak prevention and over-the-counter medication.

Key deliverable:
1. Document describing the health education materials that were developed and the ways in which they were used.

415 Izhevsk Mayorate
$99,900
Address: 426000 Izhevsk, Pushkinskaya St., 276
Contact: Nina Zagrebina
Tel: (3412) 224590, 229580, fax: (3412) 228494

Izhevsk is the recipient of one of three "Healthy Communities" grants, based on the WHO Healthy Cities project. Izhevsk has involved all sectors of the community including schools, government, and the health care sector to improve the status of maternal and child health. They also hosted a two-day practical conference designed for implementing "Healthy Cities" Programs which was attended by officials from many cities around Russia.

Key deliverables:
1. Report on community health status.
2. Analytical report on the results of sociological survey "Izhevsk citizens' health attitudes."

416 Kostroma Mayorate
$70,000
Address: 165000 Kostroma, Sovietskaya Square
Contact: Tamara Makarova
Tel: (0942) 566515, 574329, fax: (0942) 578204

Kostroma is a recipient of a "Healthy Community" grant. The grant funded the development of the program, "Creating the Family Planning Center" which has improved the status of children's and women's health by means of decreasing the number of abortions and to prevent unwanted pregnancies.

Key deliverables:
1. List of videotapes produced with birth control and sex education materials.
2. List of methodological and lecture materials.
3. Seminar programs.
4. Stories for local periodicals.

417 Lipetsk Mayorate
$50,000
Address: 398001, Lipetsk, Sovietskaya Ul., 68
Contact: Elena Melnikovskaya
Tel: (0742) 776617, 254267, fax: 744430

Lipetsk is also a participant in the "Healthy Communities" program. The grant helped to increase the coverage of vaccination, diagnose and analyze post-vaccination complications, analyze the cause for morbidity among vaccinated persons, and create an automated program for planning and registration of individual immunization.

Key deliverables:
1. Description of the community health and environment status.
2. Articles in newspapers and memos for parents.
3. Immunologist work schedule for children's polyclinics.
4. Schedule of public relations activities.

5. Vaccination check-up schedules for children's polyclinics.
6. Vaccination coverage records (diphtheria, polio, whooping cough, measles, epidemic parotitis) on 1995 and 1996.
7. Report of the Central State Sanitary and Epidemiology Surveillance on incidence for the above-indicated infections in 1995 and 1996.
8. Software for vaccination needs of children's polyclinics.

422 Russian Charitable Fund "No to Alcoholism and Drug Addiction"
$25,000
Address: Moscow, Shvernika St. 10-a
Contact: Larissa Goncharova
Tel: 1263475, fax: 3107076
E-mail: nan@glas.apc.org

The Russian Non-Profit Foundation No to Alcohol and Drug Abuse (NAN) was formed in 1987 to study the possibility of adapting American methods of treatment and prevention of alcohol and drug addiction to the Russian experience. The project developed a training course for health care leaders, managers of treatment and rehabilitation programs, and local health care administrators at the Social Academy of the NAN Foundation.

Key deliverables:
1. Materials for workshop participants, including:
   - plan/schedule for the whole training period duration
   - plans for each workday, timetables
   - list of participants
   - resumes of all the teachers/trainers
   - abstracts of lectures
   - survey forms
   - exhibits, tests, etc. for group and individual work.
2. Brochure "Theory & Practice of Medical & Social Work in Marcology."

429 AESOP Center
$25,000
Address: P.O. Box 27-121552 Moscow, Russia
Contact: Kevin J. Gardner
Tel: (095) 1418315, fax: 1418315

The AESOP Center was registered in April 1993 as non-governmental community organization in Moscow. Over the years, the mandate of the AESOP Center has expanded from HIV/AIDS prevention and women's health issues to sexual health promotion in general, including sexuality and sex education. Under the grant, AESOP established the Sexual Health Coalition and trained NGO leaders in the area of sexual health.

Key deliverables:
1. Sexual Health Training Manuals.
2. Other training materials.
3. Five electronic accounts in GlasNet for Coalition members/affiliates.

Efficiency Improvement of In-Patient Care

30.004 Novoaltaisk Hospital
$42,000
Address: 656035, Barnaul, Nikitina St., 59a
Contact: L.Ya. Litvinenko
Tel: (3852) 230827, 233445, 237727

Novoaltaisk Hospital developed a multi-level system of in-patient care. This project included the following steps: determining the types of sub-acute care units required by the hospital, developing criteria for appropriate lengths of stay for a range of diagnoses, and creating and implementing payment guidelines for each level of care.

Key deliverables:

1. A detailed analytical report describing the current methodology for analyzing and determining hospital bed and labor capacity requirements and utilization and for allocating resources.
2. A detailed analytical report describing the methodology for determining the expected labor and hospital bed capacity requirements by level and type of non-acute care under a reorganized in-patient structure.
3. A report and computer spreadsheet model describing # health facilities, equipment, labor capacity and the hospital bed capacity and utilization in Altai Krai for regional, district and village hospitals.
4. A report describing recommendations for: restructuring hospitals to provide an appropriate number of beds and equipment for each level of care, (according to revised standards for clinical requirements).
5. A report describing recommendations for: increasing the internal efficiency of the inpatient care sector.

407 Dubna Central Municipal Hospital
$31,000
Address: Dubna, 30 Makarenko St.
Contact: Victor Dmitriev, Irina Makarova
Tel: (221) 48738 (Dmitriev), (095) 9361246 (Makarova), fax (221) 48261 (Makarova)

Under this grant, the Dubna Central Municipal Hospital improved the quality of care provided to acute myocardial infarction patients by improving the diagnosis and treatment process for patients during and after the period of hospitalization. The hospital also established an intensive physical, psychological and social rehabilitation program for patients following their discharge from the hospital.

Key deliverables:
1. Document describing the training program in intensive rehabilitation created by the hospital for intensive care nurses.
2. Document summarizing the computer software and system designed to improve the scheduling of physicians and operating room associated with treating myocardial infarct patients.
3. Document describing the results of the analysis of the cost of treating and rehabilitating myocardial infarct patients using the previous method and using the new intensive rehabilitation method and describing the managerial, organizational and personnel changes required to implement the new method of intensive rehabilitation.
4. Evaluation of work done by Dubna Hospital
5. Critical Issues of Treatment of Chronic Cases of Ischemia Heart Disease

409 Stavropol Krai Clinical Hospital
$50,000
Address: 355030 Stavropol, Semashko St. 1
Tel: (86522) 9-70-32

The main objective of this program was to reduce the average length of patient stay in the Stavropol Hospital. This goal was achieved through such activities as creation of new methods for patient assessment, training and education for staff members, more efficient use of equipment, and development of better systems of quality control.

Key deliverables:
1. Report describing procedures implemented to reduce pre-operation length of stay, including procedures to provide timely diagnostic services and to reduce duplication of diagnostic and treatment services.
2. Report describing the three level quality assurance system implemented in the Krai Hospital and the impact of this system on the quality of care being provided.

411 Central Medical Unit 122, St. Petersburg
$50,000
Address: 194291, St. Petersburg, Prospect Cultury, 4

Contact: Rimma Grigorieva
Tel: (812) 5599743, 5580508

Under the grant, CMU 122 has improved the cost-effectiveness of in-patient medical care. The average length of stay has decreased as the project strengthened the continuity of patient treatment between the out-patient and in-patient sector and introduces modern treatment methods which will allow for more pre- and post-hospital procedures to be performed in an out-patient setting. A set of diagnoses which can be treated more effectively in an out-patient setting was also be identified, thus decreasing the number of inappropriate hospital admissions.

Key deliverables:
1. Document describing clinical pathways and standards of care developed for most frequent in-patient and out-patient diagnoses.
2. Document describing clinical procedures and pre-hospitalization and post hospitalization procedures that were transferred from the in-patient to the out-patient setting
3. Document describing the procedures that were implemented to increase the continuity of care between the polyclinic and hospital setting and to provide each patient with a one physician responsible for coordinating out-patient and in-patient care.
4. Document describing the diagnostic and treatment procedures that were modernized, updated and made more cost-effective under the grant program and the methods by which these diagnoses and treatments were made more cost-effective.
5. Document describing the system that was implemented to improve the scheduling of surgical facilities and surgeons.

414 Sverdlovsk Oblast Territorial Fund
$49,800
Address: 620219, Ekaterinburg, GSP-1015, Prospect Lenina 60A
Contact: Sergei Leontiev
Tel: (3432) 573871, fax: (3432) 615266

This program addressed two major contributing factors to the inefficient allocation of health resources. First, the territorial fund coordinated the development of appropriate post-operative nursing and rehabilitation services for cardiac patients in two principle health facilities in Ekaterinburg. Second, the fund coordinated the development and implementation of an integrated information system that will provide fund managers with the routine information they need to allocate health resources.

Key deliverables:
1. Document describing information needs of territorial fund managers and specifications for all new software developed under grant program.
2. Document describing the territorial fund management decisions that were influenced by the information that is provided by the new software and the impact of having additional information on the ability to make informed decisions..
3. Document describing the improved decision making capability that resulted from the newly available information.
4. Document describing the training materials and curricula that were used to train territorial fund managers to use newly available information for improved decision making.
5. Document describing the cost-effectiveness analysis of home-based nursing and rehabilitation care and the conclusions.
6. Document describing the personnel and equipment needed to implement home-based nursing and rehabilitation service, the actual services provided, and the organizational and managerial changes made to implement the home-based system.

423 Central Clinical Hospital the President's Administrative Department Medical Center
$45,000
Address: 121356, Moscow, Timoshenko St., 15

Contact: Victor Tarasov
Tel: 1409834, fax: 1404250

The Central Clinical Hospital is the largest and most advanced treatment-diagnostic institution within the structure of the Russian Federation President's Administrative Department Medical Center. The hospital pursued a “Quality Indicator Project” with the goal of improving health care delivery. The project was based on the Maryland Hospital Association indicator system in hospital management.

Key deliverables:
1. Maryland Hospital Association (the chapters corresponding to the quality indicators selected for implementation in the Hospital).
2. The Manual on application of quality indicator system of Maryland Hospital Association to Russian hospital practice.

APPENDIX G2

MAJOR ACCOMPLISHMENTS

Appendix G2: Major Accomplishments

Establishment of Free-Standing General Practices

30.001 ASOPO-Zhizn Insurance Company
12/1/94-11/30/95
$50,000

Major Accomplishments:

1) Established 3 private general practices within government polyclinics.

2) Trained doctors and nurses in special programs and allowed residents to sign up for a visit to a general practice doctor for basic explanations of the procedure of signing up for a visit to a practice doctor or polyclinic specialist.

3) Gave the people of the Novosibirsk Region a right to a free choice of doctors for the first time.

4) Began to use capitation payments for the financing of the general practices.

30.003 Altai Krai Health Care Committee
2/15/95-5/31/96
$71,200

Major Accomplishments:

1) Established 2 private general practices within government polyclinics and purchased equipment for 3 additional practices.

2) Finalized the following documents:

- Polyclinics restructuring concept including mechanisms of realizing financial, administrative and operational independence of general practices/family physicians` work;
- Legal documents necessary for restructuring and approval by the local administration of new functions and responsibilities of the health sector officials which follow family practices opening at polyclinics;
- Standard form contracts regulating relations between payers and family practice room workers, and between room workers and polyclinics; and
- The order of licensing and accreditation of family practice room workers.

400 Tula-Albany Health Care Insurance Company
2/1/95-8/31/96
$99,900

Major Accomplishments: Established the first non-for-profit health maintenance organization in Russia as part of the mandatory health insurance system. The HMO provides an integrated set of in-patient and out-patient services and provides insurance to cover the costs of these services and developed a computer-based program to collect the required statistics and other information for the HMO.

404 MedExpress Insurance Company
5/25/95-5/31/96
$43,300

Major Accomplishments:

1) Developed a package of documents to legalize GPs in the MHI framework as partners.

2) Opened a general practitioner's office within the mandatory insurance system (3,735 patients enrolled as of March 1996) with the following outcomes:
   - the number of GP emergency calls were 2.5-3 times lower than that for the polyclinic physicians;
   - GP office patient admissions were 2.3-2.8 times lower than that for the Central District providers; and
   - the GPs devote about 3 times as much time to each patient visit as other St. Petersburg providers.

Development of New Payment Methods

30.002 Kemerovo Institute of Social and Economic Problems of Health Care
2/1/95-7/31/95
$58,400

Major Accomplishments:

1) Developed a new classification code of outpatient services and medical economic standards (MES) used to regulate care delivery technology.

2) Developed DRG-based methods of payment for outpatient care delivery.

30.005 Tomsk Health Care Committee
5/12/95-7/31/96
$45,400

Major Accomplishment: Developed and introduced new method of payment for healthcare at two inpatient facilities.

402 LangMedService Insurance Company
4/21/95-8/31/96
$57,677

Major Accomplishment: Elaborated and implemented a computer-aided system in the health insurance registration department and trained senior officials, insurance agents, and accountants in this system.

408 Vladivostok Municipal Hospital No. 2
9/25/95-9/25/96
$50,000

Major Accomplishments:

1) Designed and implemented a hospital MIS for cost accounting and managing financial transactions within the hospital and between the hospital and insurance companies.

2) Developed a database for collecting, storage and analysis of hard information on hospital resources, and discharged and current patients. It includes a DRG reference guide, a paraclinical services reference guide, surgical and medical procedures, and a complete list of Primorsky Krai health care facilities.

3) Developed the Manual *Integrated System of Cost Accounting for Hospital Inpatient Care which* describes methods of hospital cost-accounting along with procedures of assigning indirect costs and billing TFMHI. The manual is addressed to department heads so they could learn the basics of the new system of price-setting.

4) Developed the following software:
   - hosp.exe - a program for input of data describing finished cases and services provided
   - outlay.exe - cost-accounting department-specific software.

434 Kaluga Mandatory Health Insurance Fund
2/1/96-10/31/96
$95,000

Major Accomplishment: Developed working pilot projects in which Russian and American health care leaders demonstrate the value of reforms for a) quality of care; b) new payment methods for hospitals, polyclinics, and physicians that have incentives for consumer choice and improved provider performance; and c) new health management information systems services delivery and/or health care financing.

435 Tver Oblast Mandatory Health Insurance Fund
2/1/96-10/31/97
$95,000

Major Accomplishments:

1) The provider payment method was implemented in five pilot sites, encouraging the general provider's interest in improved quality and cost-efficiency of care with the responsibility and interest of each clinical unit (hospital, polyclinic, paraclinical service, etc.)

2) The structure of medical services is being optimized to meet the actual requirements in bed capacity and clinical personnel:

    - new medical services were introduced (day and home care, family doctor)
    - the priority is moving from inpatient to outpatient care and from treatment to preventive care

3) The first steps have been taken in implementing the uniform hospital payment method.

4) Incentives have been developed for physicians limiting inappropriate referrals for screening and remunerating for high-quality medical services provided including additional ones to patients transferred from the inpatient department to the polyclinic.

5) The process has begun for estimating all costs involved.

436 Cherepanovo District Hospital and Novosibirsk Oblast MHIF
2/1/96-9/30/96
$50,000

Major Accomplishment: Developed a cost accounting system for the Cherepanovo Regional Hospital.

437 The Tula Territorial Fund of Mandatory Health Insurance
1/15/96-10/15/96
$25,000

Major Accomplishments: Developed a system of reform in the methods of payment to health care providers and produced the following documents:

1. Draft Charter of the Tula Albany Non-Profit Polyclinic Fund,
2. Draft Decision by the Mayor of Tula "On Establishment of the TONPPF,"
3. Contract between HMO and physicians,
4. Contract between HMO and hospital,
5. Contract between HMO and external providers,
6. Cost estimate and costs analysis of Hospital 1,
7. Calculation of the capitation rate for the HMO complex,
8. Budgeting the polyclinic and primary care units,
9. HMO payment model,

10. Medical programs and new procedures and methods of treatment implemented at Hospital 1 under the grant program, and
11. Software for computing costs of Hospital.

Dissemination and Leadership Development

418 Saint Petersburg Medical Academy
12/1/95-10/31/96
$50,000

Major Accomplishment: Developed innovative training programs for Russian managers in the areas of financial planning and management, human health care management, new methods of medical insurance, and medical market research:

1) English textbooks, required for training the faculty, in health management, marketing of medical services, statistics, financial and economic analysis, insurance, and health economics were translated into Russian.
2) The faculty was trained in classical economics; management; marketing of medical services; insurance and special issues, in particular, the possibility of the off-budget provider payment including credit notes, study of tax legislation and investment perspective.
3) Graduate level curricula were drafted for the following:
    - basics of economics, market relationships in health sector, basics of health insurance and entrepreneurship
    - modern methods of economic analysis and optimization of provider economic activities
    - economics, market relationships in health sector, basics of health insurance and entrepreneurship (see Summary Materials).
4) The layouts of the following manuals were written and submitted for printing:
    - statistical and economic analysis in improving provider financial and clinical efficiency
    - computer technologies in processing health manager's materials
    - basics of provider risks management.
5) Two software programs were designed:
    - software for evaluation of the trainee initial knowledge
    - software for the marketing research related to the graduate health manager training.
6) The perspective of enrolling the unemployed for additional health manager training was evaluated in addition to the market for educational services and graduate manager training programs.
7) Phase 1 of the training program, designed under ZRP grant program, was implemented and attended by 31 Chief Doctors, their deputies, upcoming health managers, economists and chiefs of clinical departments to cover the basics of health economics, market relationships, basics of health insurance and entrepreneurship in health care.
8) Analogous faculty training was launched by other educational establishments.

419 Regional Fund of Compulsory Medical Insurance, Rostov Oblast
1/15/96-10/15/96
$55,000

Major Accomplishments:

1) Ran *3 workshops* for consultants on planning training programs for managers of independent healthcare quality expertise.

2) Held *10 orientation sessions* on interdepartmental independent health care quality expertise under MHI system, for health care managers of Rostov *Oblast (total attendance of 151 participants*).

Developed and published training program materials "Organization of Independent Evaluation of Quality of Health Care in MHI System".

Developed *curricula of correspondence/workshop training programs (156 hours each)*.

3) Published "Organization of Independent Evaluation of Quality of Health Care in MHI System" hand-out materials for each category of managers.

4) Held 2 "pilot" training sessions for health care quality managers held in Rostov Training Center of MHI.

5) Developed business plan of regular training health care quality managers in Rostov Training Center of MHI. Three training cycles following the curricula above will be organized for health care managers of Rostov Oblast and other territories of the RF.

6) Developed draft of the "Provision on Independent Expert Evaluation of Quality of Health Care in Rostov Oblast" was developed by Rostov Oblast Interdepartmental Commission on Quality of Health Care. The Commission is third-party peer-review organization evaluating quality of care throughout Rostov Oblast.

7) Published 10 articles on QA efforts in printed articles, mass media, and professional journals.

8) Grant Program participants appeared in two radio talks and two TV discussions of health care quality assurance problems (courtesy to *DON-TR* TV/radio).

9) Finally, a number of proposals generated under the Grant Program were approved by ROFMHI (Rostov Oblast Fund of Mandatory Health Insurance) and included into regional regulations on external and independent QA in health care.

420 Association of Don Physicians
11/1/95-10/1/96
$50,000

Major Accomplishments:

1) Registered Association of Don Physicians.

2) Published and distributed six issues of the monthly "Don Physicians Newsletter." The circulation reached 2,000 two months before the schedule.

3) Created and maintain a database of physicians and healthcare professionals in the Rostov region.

421 Regional Educational-Methodological Center of the Far Eastern Medical
2/1/96-10/31/96
$65,000

Major Accomplishments:

1) The Health Economics and Management curriculum was developed and launched in February 1997 for the first time for the 6th year students of the FEMU physician and pediatrician schools.

2) The one-year Health Management curriculum was developed and launched on February 24, 1997 (also by correspondence) for 20 students matriculated on a competitive basis. (Funding provided by the FMHIF.)

3) The FETC instructors were trained at the Khabarovsk Economics and Law Academy, MU, Academy of National Economy with the Russian Government, and study tour to Kentucky University (KU).

4) The international health insurance and health reform conference was held in October 1996 in Khabarovsk, attended by the Minister of Health, FMHIF Executive Director, and representative of the leading health research institutes and KU (Conference materials were entered into Internet.)

5) Training was provided with all necessary equipment purchased with the grant.

6) A conference was held based on the grant deliverables, attended by the deans of the Family Care, Health Organization and Economics colleges of the Far East high medical schools.

7) The deliverables on the grant program outcomes were highlighted at the final ZdravReform Program in Moscow.

424 Leadership Training Center Under "MedSocEconInform" Public Health Institute
2/12/96-9/30/96
$54,990

Major Accomplishments:

1) An advanced workshop based on the multi-purpose training program Information Support to the Health Management Reform was held in Moscow. Its goal was to train mangers of the Ministry of Health how to implement health reform activities on their own. The workshop covered the following topics:
   - role of electronic equipment in mandatory health insurance programs
   - role of medical information systems
   - choice of health-related software
   - acquiring skills to operate computers OS
   - design of PC software for users at the Ministry of Health
   - independent work with PC
   - provision of user guidelines.

2) A workshop was held with the local Health Committee executives on Russia's Health Care under the New Economic Mechanism. The goal of the workshop was to upgrade the skills of the local Health Committee executives aiming to implement the specific regional health reform programs. The workshop covered the following topics:
   - strategic planning considering the demographic situation
   - main guidelines of health reform
   - system analysis of local health services and facilities of various types (general practice, polyclinic, diagnostic center, dispensary, etc.)
   - introduction of medical and organizational technologies in the regional and care provider level
   - health economics and insurance
   - financial analysis of health care
   - health management.

3) Four workshops for health managers studies were organized directly on sites in the territories which were attended by over 200 local health managers. The objectives of the workshops were:
   - evaluate the demographic situation in the territories.
   - discuss the efficient use of the resources available.

- familiarize the students with the process of implementing quality assurance methods at health facilities.
- discuss the approaches to shifting priority from inpatient care to primary and community care (general practitioner, family doctor, group GP).
- improve the specialty knowledge of the modern personnel management methods.
- provision of manuals.

425 Academy of National Economy Under the Government of Russian Federation, Business Management Center, Institute for Senior Executives
12/1/95-10/1/96
$70,000

Major Accomplishments: Established a management training program for chief physicians of medical establishments:

1) Developed 3 curricula. The first two cover the basics of Russian healthcare management and the final one provides a practical implementation of the knowledge already received (including from their international experience) for the solution of specific provider management problems.
2) Trained three groups of health managers (68 managers), and adjusted and further developed the manager upgrading program.
3) Prepared and published manager upgrading manuals.
4) Filmed videotape which cover the project outcomes.
5) Evaluated quality of the studies based on the task five-point survey form.

426 Siberian Fund of Management Development
11/1/95-10/31/96
$65,000

Major Accomplishments:

1) The SMSIDF enrolled three groups of students (81 instead of 60 as planned) for a two-year training, both daytime and by correspondence: 26 in November 1995, 21 in March 1996, and 34 in October 1996. Students were enrolled from 16 territories across Siberia and the Far East .
2) Conditions were created for the training process: a classroom was leased and equipment was provided (PC, copier, overhead projector and other).
3) The two-year advanced manager education curriculum was developed (both day time classes and by correspondence).
4) The following manuals were developed and distributed to the students and health managers, certain TMHIFs and health insurance organizations:
   - Mandatory Health Insurance.
   - Basics of Health Economics.
   - Health Care Management and Marketing of Medical Services.
   - Basics of Health Care Structure.
   - Vital Statistics.
   - Voluntary Health Insurance.
   - Personnel Management.
   - MHI-related training software.
   - Training software on vital statistics and health insurance.
   - Training software on health insurance.
5) Two curricula were developed in advance studies in health management for care providers, TMHIFs, and health insurance organizations.

427 Novosibirsk State Academy of Economy and Management
1/15/96-10/31/96
$65,000

Major Accomplishments: The grant program was designed to train healthcare managers and experts to meet modern requirements of professional flexibility, business-like thinking, so they could effectively run and reform health care in existing unstable and unpredictable financial environments. Program implementation resulted in:

1) New model of training and retraining for healthcare workers in economics and management.

2) Enhanced educational level and professional skills of health care leaders in priorities selection, oriented towards the future possibilities in the development of health care facilities both in their social and economic aspects, and permitting to efficiently manage the controlled factors and allow for the uncontrolled.

3) 454 pages of methodological materials covering subjects studied in training programs handed to participants. Developed and tested methods of training in:

   - Strategic management, and planning.
   - Health care organization.
   - Health care management.
   - Financial management in health care.
   - Marketing of health services.
   - Quality of care.
   - Information systems in health care.
   - Sociology and psychology of management.
   - Strategy design, comparison of business plan and budget (guidelines).

430 All-Russia Nurses Association
1/15/96-10/31/96
$75,000

Major Accomplishments: Developed and strengthened a sustainable All-Russia Nurses Association (ARNA) so that it would advocate for the needs of practicing nurses, speak on behalf of nurses on issues of health care policy, and serve as clearinghouse of information on nursing:

1) Redeveloped organization structure of ARNA.

2) Developed and approved ARNA's Work Plans for 1996 and 1997 which included targets specified in this project and continuation of activities on the ARNA's Development Project in 1997.

3) Built up ARNA's membership from 3,058 members when the project started (of which about 3,000 represented Leningrad Oblast Association) to 7,270 members (of which about 4,055 represented members from Nurses' Associations in Yaroslavl, Sverdlovsk, Samara, and Komi, and 215 individual members representing nurses' associations of republics and oblasts of the Russian Federation).

4) Published the *"Vestnik Medsestrinskikh Associaciy Rossii" (Bulletin of Nurses' Associations of Russia)* as quarterly supplement to *"Medsestrinskoye Delo" (Nursing Affairs)* journal. Although, as of January 1996, they planned to issue the bulletins on a quarterly basis, five issues had been distributed as of October 1996.

5) Materials on ARNA's and regional associations' activities appeared in central and regional press: *Medicinskaya Gazeta ("Medical Paper"), Medicinskiy Vestnik ("Medical Messenger"), Chas-Pik ("Peak Hour"), Sankt-Peterburgskiye Vedomosty ("St. Petersburg Bulletins"), Medicina dla Vas ("Medicine for You").*

6) Held the Third Russian National Conference on Nursing, bringing together 147 delegates -- head nurses of RF territories and directors of nurses' colleges -- representing 44 subjects of the Russian Federation.

7) Arranged training for 40 head nurses of Russian regions at the Department of Higher Education in Nursing, St. Petersburg Medical Academy.

8) Instituted the badge of honor, *Russian Sister of Mercy* to mark nurse practitioners and educators referenced by regional associations.

431 Moscow Association of Health Insurance Organizations
12/1/95-5/1/95
$60,000

Major Accomplishment: Published articles on timely subjects in the journal *Health Insurance*, the newspaper *Medical Courier*, and in general interest papers such as *Izvestia* and *Trud*.

1) Special issue of the Meditsinskoye Strakhovaniye (60 pages, color, circulation: 5 000)
2) Special issue of the Meditsinsky Vestnik (16 pages, two colors, circulation: 30 000), April 16-30, 1996
3) Article by A.Yanovsky "Not Extra Middlemen But Authorized MHI Partners!" in the Meditsinskaya Gazeta, March 6, 1996 (circulation: 55 000)
4) Article by L.Arinicheva "Independent Expertise" in the Moskovskaya Pravda, February 27, 1996 (circulation: 408 000)
5) Article by N.Smetanina "Who Will Protect the Patient?" in the Moskovskaya Pravda, March 26, 1996 (circulation: 408 000)
6) Article by LBerestov "The Whole Family Will be Treated in the GP Office" in the Rossiyskiye Vesti, April 27, 1996 (circulation: 130 000)
7) Article by L.Sholpo "Doctor, Cure Yourself" in the Trud, May 13, 1996 (circulation: 1 380 439)
8) Article by B.Dudenkov is on the list of publications scheduled in the Trud for May 1996
9) Article by M.Zurabov is on the list of publications scheduled in the Izvestia for may 1996

432 Foundation for the Development of Health Care Management Training Program
1/1/96-10/30/96
$70,000

Major Accomplishments:

1) Established AUPHA Russia, which is operating as an organizer and coordinator of the development and evaluation of health manager training programs, as well as their implementation. Many meetings at various levels took place under the grant program, on a wide range of tasks from the integration of curricula development and implementation to cooperation and coordination in the organization of workshops.

2) Enhanced cooperation between the training programs developed by organizing meetings and workshops to provide support to advanced studies of health managers, faculty and researchers, including the annual AUPHA conference which allowed the faculty to determine priorities for further development.

3) Developed Information Center which became a good foundation for development of high-quality curricula. The IC concentrates both manuals and software (diskettes, CD-ROM) and is able to draw on the Internet database. The potentially important role of IC was confirmed by the interest to it of the learned faculty, students and health leaders.

4) Published 2 issues of the HMTPF newsletter (each circulated to 2,000 recipients) which describe the health care management curricula from Moscow, Novosibirsk and Khabarovsk partnerships.

5) Started and held 2 annual ceremonies to give awards to the winners of the Russian Best Health Initiative competition.

433 Russian Academy of Medical Sciences, Semashko Institute
10/5/95-7/15/96
$37,550

Major Accomplishments: Published five special supplements on current health issues with 22 articles prepared by 40 authors in the journal, *The Problems of Social Hygiene and the History of Medicine.* This led to key reform provisions, effects in specific regions, improved coordination and health leader professionalism. A special set of stories related to structural changes in health care reflected the reform processes ongoing in 17 constituent parts of the Russian Federation. Additionally, conferences and workshops held in Vladimir, Irkutsk, Kaliningrad, Krasnodar, Moscow and Tyumen became sources of information and venues for discussing the main reform guidelines and presentations by health leaders.

Healthy Lifestyle Promotion

401 Nizhny Novgorod Alcoholism Treatment Program - "Center of Twelve Steps"
2/15/95-6/30/96
$32,312

Major Accomplishment: Established a new alcoholism treatment center in Nizhny Novgorod based on the "Disease Model Concept" and the Alcoholics Anonymous model.

403 Beam of Hope Charitable Association
6/1/95-11/30/95
$23,000

Major Accomplishments: 1) Examined and screened 300 children who are disabled, orphaned or living in multi-children and incomplete families, and collected the data for a cost-effectiveness report; and 2) Held seminar on "Healthy Respiration for Children and Those Who Bring Them Up." The seminar was presided over by Corresponding Member of the Russian Academy of Sciences Yu.M.Ovchinnikov.

405 St. Petersburg Mayorate
6/1/95-11/30/95
$99,840

Major Accomplishments: Wide-reaching multi-media health promotion campaign to provide the population of St. Petersburg with basic information on personal health, disease and outbreak prevention and over-the-counter medication. Methods included:

1) Produced six television and four radio public service announcements aired under "pro bono" contracts with Leningrad TV and radio broadcast stations ("pro bono" is a concept they were a little slow to grasp but they've now jumped on the bandwagon!).

2) Conducted three focus groups to critique and edit psa's.

3) Held an art contest in St. Petersburg schools to have school children draw their image of a healthy family; winning entry is log for entire year of "Healthy Family of St. Petersburg".

4) Printed and distributed 50,000 brochures to all pharmacies and 150 out-patient clinics throughout the city of St. Petersburg -- 10,000 were sent through the mail to selected demographic groups.

5) Hung 1,000 posters in the metro stations, outpatients clinics and pharmacies.

6) Produced and mailed 2,000 1996 pocket calendars.

7) Inspired ongoing weekly newspapers articles supporting the campaign themes.

8) Fostered formation of groups to continue campaign upon completion.

9) Supported incorporating preventative health care and healthy lifestyle in public school curriculum by providing education opportunities for administrative personnel in the Department of Education.

415 Izhevsk Mayorate
10/4/95-10/1/96
$99,900

Major Accomplishments: Involved all sectors of the community including schools, government, and the health care sector to improve the status of maternal and child health:

1) Described and evaluated current public health status and environmental conditions in Izhevsk.

2) Conducted sociological research and public opinion surveys which attempted to:
   - find out citizens' perception of their status;
   - expose major health problems;
   - find out the degree of public interest in health status improvement, and opportunities and obstacles to improvement;
   - determine major factors influencing citizens' health, as they feel it;
   - describe variables that determine mental and social self-perception of people;
   - evaluate current level of people's satisfaction with community health care system, and to specify needs for its improvement; and
   - expose major problems with children health and find out basic family needs in pediatric care.

3) Designed a program of training health professionals, "Prepared Birth", based on domestic expertise and ASPO-Lamaz program (as approved by the Ministry of Health of RF). Trained specialists in Ob/Gyn, neonatal care, pediatric care, and mental health.

4) Valeological education classes were taught once a week for a year. 35 hours cumulative for each of 375 students of grades through seventh to eleventh. The same 375 students attended family education classes -- once a week for ten weeks in groups of 10 to 12 pupils. Grades 7 - 11 of School #45 (420 pupils) also attended family education classes.

5) Conducted an international conference on WHO *Healthy Communities* Project in Russia, with participation of 18 Russian communities. Outputs of the conference include:
   - Collective manuscript on problems and prospects of environment and health improvement as the result of shared efforts of a number of small work teams.
   - Resolution supporting Health for All strategy and Healthy Communities Network initiative proposed by four Russian cities.
   - 25-minute video covering the conference.

416 Kostroma Mayorate
2/1/96-10/31/96
$70,000

Major Accomplishments: Educational campaign to improve the status of children's and women's health by decreasing the number of abortions and preventing unwanted pregnancies:

1) *Reduction in abortion rate* by 7 to 8%.
2) Held *training workshops* for 341 physicians, nurses, teachers, and psychologists.
3) Eighteen *visitations of summer camps* for teenagers resulted in reaching 437 adolescents with lectures and counseling on sex-related issues
4) Physicians of the Center visited *schools* with 36 lectures and consultations reaching 465 students and two video presentations attended by 32 girls.
5) Twelve lectures presented in *evening schools* were attended by 197 students and two video presentations attended by 23 girls.
6) In *polyclinics*, 13 lectures were read with an audience of 214 physicians and practitioners, and 5 video presentations were shown with an audience of 89 physicians and nurses
7) In *community ob/gyn clinics*, 25 lectures were presented with an attendance of 278.
8) Distributed a *survey* which covered 200 school students and 100 patients of ob/gyn clinics.
9) *The Center of Family Planning* had 614 visitors, were consulted by 595 physicians, consulted by 19 lawyers, held 31 video demonstrations, distributed 113 computerized selections on contraception, distributed 1,688 contraceptives, distributed 329 brochures and booklets, produced 3 videos which aired on the mass media, held TV discussions of family planning and birth control,
10) *Kostromskiye Vedomosty* (the most popular of local newspapers) published three materials, "Modern Contraceptive Devices," "Let Us Speak of the Most Intimate," and "Reflecting on New Generations' Future"

417 Lipetsk Mayorate
2/1/96-10/31/96
$50,000

Major Accomplishments: The goal of the grant program is improving immunization aiming to increase the coverage of Lipetsk children. The following accomplishments were made:

1) Effected changes in psychology - everybody's attention became more focused on the immunization problems including the community at large, local government, top managers of companies, institutions, clergymen and all health workers responsible for various sections of the immunization activities,
2) Established a course of immunization training for pediatricians
3) Increased patients covered by consultations
4) Reviewed immunization status at Lipetsk children's polyclinics
5) Established immunization center (IC) in Lipetsk. The establishment of the IC has considerably affected the improvement of immunizations records, expansion of the lab facilities and scope of research.
6) Made presentations at a conference in Lipetsk Oblast and published the recaps in the press.
7) Developed software for electronic tracking, reporting and planning immunizations (ITRPS) for children's polyclinics

422 Russian Charitable Fund "No to Alcoholism and Drug Addiction"
1/1/96-10/31/96
$25,000

Major Accomplishments:

1) 36 specialists, including health programs leaders and narcologists, have been trained in basic management, as well as the possibility of mutual training, information and experience exchange.
2) The ideology of the training has been elaborated to provide the most possible mutual approach of the positions of the psychiatrists and narcologists with the leaders of self-and -mutual help movement (AA, AN, Al-Anon).
3) Elaborated the normative documentation on listing regular appointments of the health facilities with the " specialist in cultural work," as well as job specifications of the mentioned specialists.
4) The educational materials have been elaborated for the graduates of the program "Basic Management and Medical-Cultural Programs in Narcology" which included normative documentation.
5) The analytical material " Theory and practice in medical -cultural work in narcology" has been elaborated and issued.
6) The educational materials have been elaborated for the graduates of the program "Basic Management and Medical-cultural Programs in narcology" which included normative documentation.

429 AESOP Center
11/1/95-5/1/95
$25,000

Major Accomplishment: Established the Sexual Health Coalition and trained NGO leaders in the area of sexual health.

1) Developed Sexual Health Training Manual - Developed by AESOP and submitted to Abt in Russian on computer diskette for future publication and dissemination.

2) Developed other training materials - Various fact and information sheets, calendars, and condoms distributed to participants of the training seminars and other events organized by AESOP during this project; submitted to Abt with previous reports.

3) Added five new electronic mail (e-mail) accounts in GlasNet for affiliates of this project:

Efficiency Improvement of In-Patient Care

30.004 Novoaltaisk Hospital
2/15/95-11/30/95
$42,000

Major Accomplishment: Developed and implemented a methodology that was used to estimate personnel, facility, equipment and financial resource needs under a multi-level system of in-patient care. The outcomes of their research showed that inpatient care reform is timely and appropriate provided the respective laws are adopted, provider payment methods are modified, and medical and economic standards are developed and approved for clinical departments of each tier

407 Dubna Central Municipal Hospital
8/1/95-5/1/96
$31,000

Major Accomplishment: Improved the quality of care provided to acute myocardial infarction patients by improving the diagnosis and treatment process for patients during and after the period of hospitalization. The

hospital also established an intensive physical, psychological and social rehabilitation program for patients following their discharge from the hospital. Additionally, the following results were seen:

1) LOS reduced for AMI patients by 37%.
2) Per AMI patient costs dropped by 21%.
3) The death rate decreased for AMI by 10.3%.
4) Home-based rehabilitation was more efficient; of the 12 economically active patients, 11 got back to work (91.7%), with 2 certified as disabled Grad 2 and 3.
5) This intensive rehabilitation experience is planned for dissemination to other care providers of Moscow Oblast.
6) Beginning May 1, 1996, DMCH introduced more positions to sustain work after grant funds are depleted.
7) more diagnostic equipment was acquired (Burdick stress-test device, US) with the grant funds.

409 Stavropol Krai Clinical Hospital
2/1/96-9/15/96
$50,000

Major Accomplishment: Reduced the average length of patient stay in the Stavropol Hospital by creating of new methods for patient assessment, training and education for staff members, more efficient use of equipment, and developing better systems of quality control.

1) Pre-operative stay decreased by .5 days -- from 3.3 to 2.8 days on average (15.2%).
2) Post-operative stay decreased by 1.4 days -- from 13.7 to 12.3 days (10.2%).
3) Average length of stay decreased by 2 days per admission.
4) To provide appropriate and timely pre-admission examination, the following services have been restructured to operate 24 hours a day:
    - endoscopy
    - gravitational blood surgery
    - angiography.
5) Introduction of fifty new medical technologies helped reduce diagnostic time by 2.8 days.
6) New Quality control system was developed and introduced.

411 Central Medical Unit 122, St. Petersburg (need to finalize when we receive final report)

8/1/95-6/30/96
$50,000

Major Accomplishments: 1) Created an outpatient surgery center combining inpatient and outpatient services, with one physician responsible for the entire care delivery process; and 2) identified a model of payment by insurance companies and territorial MHI funds for OSC services.

1) The Overnight Surgery Center (OSC) was established, with certain services transferred to it from the inpatient department aiming to optimize the inpatient surgery bed utilization.
2) The OSC payment procedures was determined involving insurance companies and the territorial mandatory health insurance fund (TMHIF), as well as the rates for OSC services were contracted.

3) The OSC surgeon began screening the patient, evaluating his status and deciding on the method and site of treatment (inpatient department or OSC).

4) The necessary pre-admission tests started being performed on the patient at OSC, which simplifies the admission procedure.

5) To optimize the performance of the inpatient department the following was done:

- the treatment standards were developed and are being implemented on most common nosologies, as well as the treatment procedures determined
- improving the surgeon utilization started with the establishment of mobile surgery teams to be serve both the inpatient department and OSC simultaneously
- fixed utilization schedules were designed for surgical departments, inpatient department surgery and OSC surgery rooms
- the integrated medical information system allowing to track patient from reception to discharge, plan the date of operation, screening, consultation, etc., format utilization reports for insurance companies, as well as monitor quality of surgery and provide for the cost-accounting

414 Sverdlovsk Oblast Territorial Fund
6/15/95-4/19/96
$49,800

Major Accomplishments:

1) Developed and implemented an integrated information system that provides fund managers with the routine information they need to allocate health resources.

2) Developed post-operative nursing and rehabilitation services for cardiac patients in two health facilities.

- Tested and adjusted post-hospital care as home care/EDCC model at a surgery clinic and at the municipal infarction center. The analogous experience was summarized at other Oblast health facilities, with the guidelines worked out for post-hospital care development.

- This experience was disseminated to the Oblast health facilities. As early as in 1995, 14 care providers used the support of the MHIF and Health Committee and deployed home care units. Completed cases totaled 5,050 (home care). City care providers have most experience, with 11 home care units deployed and 4 854 patients treated. Most patients treated under home care have been registered in Revda (2,466), Ekaterinburg (1,642) and Severouralsk (670).

423 Central Clinical Hospital the President's Administrative Department Medical Center
12/1/95-10/31/96
$45,000

Major Accomplishments: Following is the list of the objectives and the outcomes received:

1) Established a system of data collection, processing and evaluation in making hospital management decisions based on the MHA indicators. The MHA system of data collection and evaluation was replicated by CCH, with the quality indicators introduced at all 45 CCH departments.

2) Improved the MHA indicators over CCH by 10% during the grant program implementation. The MHA indicators secured a 10% and over improvement of services provided by CCH during the program implementation. Some indicators showed an improvement by the order of times except the death rate that persisted at the same level.

3) Developed and published manual on application of the MHA indicators at Russian hospitals.

4) Held workshop for health managers and hospital experts involved in the AIHA program. The workshop was attended by 120 representatives of hospitals, insurance companies and Health Committees from 10 Russian cities. 8 presentations were made. The participants appreciated the grant program outcomes. Several hospitals opted for joining the QIP.

APPENDIX G3

MANAGEMENT PROCEDURES

Appendix G3

NIS Health Care Reform Program

Small Grants Program

Management Procedures

DRAFT 3/23/94

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VIII. GRANT EVALUATION

I. Introduction

This document describes the procedures that will be used by the NIS Reform Program to manage and implement its small grants program and the responsibilities of the Program field office staff, key headquarters staff and A.I.D. in the management process. These procedures will standardize grants program management among program field offices and will ensure that the program is competitive, collaborative and consistent with AID regulations governing grants.

II. Soliciting Grant Applications

A. Grant Funding Cycles

Grant applications will be solicited and reviewed and grants will be awarded during four different cycles during the first two years of the Program. The first funding cycle will take place between May 15 and July 15, 1994, with subsequent cycles scheduled for December, 1994, June, 1995 and December 1995. If the number of grants awarded during the funding cycles is less than expected, the Program will accept applications and award grants on a year-round basis during 1994 and 1995. A limited number of grants may be awarded during an additional funding cycle in 1996.

B. Grants Agenda

Program staff, A.I.D. (Washington, Moscow, Almaty) and NIS-based colleagues will establish an agenda of issues and questions related to health finance and organization and management reform for each grant funding cycle. Grants will only be awarded to individuals or institutions who submit an application which clearly addresses an agenda issue for that cycle.

C. Geographic Focus of Grant Activities

Although the grants program will operate throughout the NIS, Program field offices will focus on identifying potential grantees and soliciting grant applications from organizations in Russia and the Central Asian Republics. Up to 60 percent of all grant awards will be made in Russia and up to 25 percent in the Central Asian Republics, with the remaining 15 percent conducted in other republics. Furthermore, within these geographic locations, the program field office will focus on identifying grantees whose activities would either be conducted in an Intensive Demonstration Site (IDS) or otherwise directly support an IDS activity.

D. Announcing Requests for Grant Applications

The Program field offices will be proactive in soliciting applications from a variety of individuals and institutions in the Program areas, particularly in the Intensive Demonstration Sites (IDS). The request for grant applications will be announced in conjunction with the grants program agenda for each funding cycle in local newspapers, professional newsletters and journals and within the health care community. The program may also organize workshops for targeted individuals and institutions to generate interest in the grants program and its agenda and to assist interested parties in developing concepts for grant activities and in preparing grant applications.

E. Standard Grant Application Format

The Program will develop a standard format for the grant application and instructions to guide those interested in preparing a grant application. The standard application format and instructions will be distributed to all interested individuals and institutions in conjunction with the request for applications.

The standard grant application will contain sections that describe: 1) The organization's capabilities, previous health sector experience and key personnel who will manage the grant activity; 2) The proposed program's objectives and rationale; 3) The proposed program's expected outputs and results; 4) The resources and activities required to achieve program outcomes; 5) The

workplan and timeline for the program, including all sub-activities; 6) A plan for monitoring and evaluating the program that includes clear benchmarks and interim products by which progress can be measured; and 7) The line item budget for the grant program. Applications which do not adhere to the standard format will not be accepted for review.

F. Submitting Grant Applications

All grant applications will be submitted to the program field offices. To be considered for a grant award, an application must be received by the deadline, follow the standard format and clearly address an issue on the grant agenda for that funding cycle. Following the announcement of the request for applications, applicants will have one month to complete and submit an application. During this time, the Program field office will assist individuals and institutions, as necessary and as requested, to complete applications that adhere to the standard format.

III. Awarding Grants

A. Competitive Selection Procedures

The Program will take the following actions to ensure that a competitive selection procedure is followed for all grant awards and to ensure against any conflict of interest between the program and potential grantees:

1. An agenda for grant applications will be developed for each funding cycle by Program staff, A.I.D. and NIS-based colleagues.

2. A description of the grants program, instructions for developing a grant application and all requests for grant applications will be widely advertised in newspapers, journals and by other means to ensure broad participation within the parameters of the overall grants program.

3. All grant applications must adhere to the standard format.

4. All applications will be evaluated by a review committee that will use published standard criteria. The review committee will consist of Program staff, and NIS-based colleagues and collaborators.

5. A grant will only be awarded if two or more applications are received and evaluated competitively.

B. Field Review of Grant Applications

The Program field offices will convene a grant review committee comprised of Program staff and NIS-based colleagues and collaborators. The review committee will use a standard set of criteria to evaluate and rank all grant proposals during a two week period following the deadline for the funding cycle.

The field offices will forward the highest ranked applications to the region's USAID Mission. The Mission will be asked to provide concurrence for an award to the potential grantees or to veto the possibility of an award to one or more of the grant applicants. If the Mission vetoes the possibility of an award, the reasons will be made clear to the organization who submitted the application and the application will receive no further consideration

C. Washington Review of Proposals

The program field offices will forward to Program headquarters staff and USAID/Washington those highest ranked applications that also received regional USAID Mission concurrence. Program headquarters and AID/Washington staff will review and provide concurrence for those applications that should be funded. Once concurrence is received, the Program field offices will then begin the process of awarding the grant.

III. **Negotiating, Preparing and Signing Grant Agreements**

A. Negotiating Final Grant Program Activity and Budget

1. Grant Program Activity Description and Scope of Work

Based on the grantee's application, which will contain a detailed section describing the grant activity, and comments provided during the grant review and award process, the field office and the grantee will develop a final scope of work for the grant activity. The scope of work will include a specific listing of all sub-activities, benchmarks, outputs, interim and final products and a timeline.

2. Grant Program Budget

a. Grant Funds

Each funded element of the grant activity presented in the budget section of the application will be reviewed to determine if it is reasonable and allowable according to applicable cost principles. The Program field office and the grantee will clearly determine the allowable costs for which the grantee may use grant funds. Based on the review of the grant activity budget by the Program field office and the Washington office, a final grant activity budget will be determined.

If the grantee has an established provisional overhead rate and includes overhead in the budget, an overhead rate will then be established for each of the grantee's accounting periods during term of the grant. The grantee's established rate will be used for the grantee's first accounting period. No later than 13 months after the close of the accounting period, the grantee will be required to submit a proposed final rate for the accounting period, together with supporting cost data. The Grants Administrator and the grantee will then negotiate a final overhead rate for the accounting period. and A final overhead rate for the grantee will also be negotiated as necessary.

b. Grantee Matching Funds

Grantees will be required to provide approximately 25 percent of the total costs of the grant program activity. The program field office will review the grantee's proposed budget to ensure that the proposed cash and in-kind contributions being provided by the grantee to achieve the required level of cost sharing adhere to the criteria and procedures for the allowability of cash and in-kind contributions.

B. Preparing and Signing the Grant Agreement

1. Standard Grant Agreement Format

The Program will use a standard format for all grant agreements that has been approved by the USAID/Washington Contracts Officer. The standard grant agreement format will facilitate preparation by the field office of the individual grant agreements and approval by USAID and Program staff of these agreements. Although individual agreements will differ in the specific details of certain sections, all grant agreements will contain the following standard sections and language:

a. A one-page grant letter which describes the overall purpose, objectives, goals and anticipated products of the grant activity and which discusses the background for grant

activity, including a description of how the grant activity will address a specific grant agenda issue. The grant letter will also list the overall amount of the grant award and the conditions of the grant.

b. A grant schedule which includes a scope of work, a timeline for implementation, clear benchmarks and indicators for monitoring and evaluation, a clear listing of intermediate and final deliverables and the financial and technical reporting requirements.

c. A line item budget by program category, including salaries, travel, commodities, other direct costs and indirect costs, that distinguishes between the costs that will be covered by the grant and those costs that will be covered (matched) by the grantee.

d. Standard clauses to ensure compliance with Abt Associates policies and USAID regulations (Handbook 13).

2. Preparing the Grant Agreement

The Program field office will prepare all grant agreement documents, using the standard grant agreement format. If the field office has reason to suspect that some change to the standard grant agreement format will be required, the field office will consult with the Abt Associates Grants Officer in Cambridge during the preparation phase.

3. Signing the Grant Agreement

The Program field office will present an unsigned copy of the grant agreement to the grantee for review. The grant agreement will contain a clause stating that the agreement is not binding until it is signed by the Abt Associates Grants Officer.

If the grantee signs the agreement, the Program Field Office Director and Field Office Grants Administrator will sign the agreement and fax the one page signature sheet to the Abt Associates Grants Officer and to the Program Director for signature. The signature sheet will then be faxed back to the field office program director.

If the grantee does not sign the agreement, those portions of the grant agreement found by the grantee to be unacceptable will be determined. The Program Field Office will consult with the Abt Associates Grants Officer in Cambridge and modify the grant agreement as necessary. Any modifications to the standard grant agreement originally approved by USAID/Washington will require a re-approval by USAID/Washington and the Program Director. The modified grant agreement will be prepared by the Program field office and presented to the grantee for signature. Once signed, the field office will follow the procedure outlined in the preceding paragraph.

IV. **Evaluation Prior to Disbursing any Grant Funds**

Grants will be awarded primarily on the basis of technical merit. A limited assessment of the financial status and administrative capacity of the organization will be also be included in the award criteria. However, once a grant has been awarded and before any funds are actually disbursed, the program field office will complete a more thorough evaluation of the Grantee's managerial capacity and the Grantee's compliance with this evaluation will be confirmed by a standard provision of the Grant Agreement:

A. Accounting, Record Keeping and Overall Financial Management System and Personnel and Travel Policies

The Program field office will review the grantee's systems to ensure that the following requirements are met. These requirements will be specified in a standard provision to the grant agreement.

1. Grantee maintains books, records, program documentation and other materials related to the grant in accordance with generally accepted accounting principles. This requirement will be specified in a standard provision of the grant agreement, and the program will assist grantees as necessary in complying with this requirement.

2. Grantee accounting records are, at a minimum, adequate to show: all costs incurred under the grant, the receipt and use of goods and services acquired under the grant, the costs of the program supplied from other sources and the overall progress of the program.

3. Grantee accounting and banking system can maintain grant funds separately from all other grantee funds.

4. Grantee systems are adequate to maintain all documentation for a three year period.

5. Grantee has adequate financial resources to complete the grant activity and to provide the required level of matching funds.

6. For grants involving the purchase of commodities, the Grantee has an adequate record system for property control and an adequate program for the orderly maintenance of government property.

7. Grantee has standard, written personnel and travel policies that are uniformly enforced and that result in personnel and travel costs which are reasonable in accordance with the applicable cost principles.

B. Managerial Capability and Eligibility

The criteria for evaluating grant applications include an assessment of the grantee's managerial capacity, previous experience, record of past performance and overall eligibility to receive a grant. Consequently, grantees will be evaluated on the following three aspects during the award process rather than at the pre-award stage, as might be the case in a non-competitive award situation:

1. An adequate record of performance, integrity and management competence with respect to planning and implementing programs.

2. The ability to complete the grant program, given all existing and prospective commitments.

3. An overall eligibility to receive a grant award.

V. Grant Management and Monitoring

A. General Responsibilities

The Program field offices' main role in managing individual grants will be to measure and evaluate the grantee's progress in achieving the grant program objectives rather than to manage the implementation of the grant's activities. The Program field office will coordinate all technical assistance necessary for grant activity implementation with the grantee and will develop a management plan for each grant. The plan will outline the schedule of training, the reporting requirements (these will also be specified in the grant document) and the schedule of meetings between the program and the grantee.

B. Training

The program field office will conduct an assessment of the grantee's training needs with respect to complying with the grant's financial management and financial and technical reporting requirements. The management plan for each grant will include a training plan. The program field office will provide training to grantees to enable them to meet the financial management and financial and technical reporting requirements of the grant.

C. Reporting Requirements

1. Financial Status Report

Grantees will submit a financial status report to the program field office grants administrator on a quarterly basis and on completion of the grant. These requirements will be documented in a standard provision of the grant document. The format for this report will be provided by the program field office. Reports will be due 30 days after the quarter has ended and 90 days after the grant has ended. Quarterly financial status reports will be on an accrual basis, when possible, and will contain information on expenditures per budget line item linked to individual grant activities and products, and will show the level of matching funds provided by the grantee against total grant expenditures.

The grantee will also be required to complete and report the results of at least one financial audit during the grant period to the program field office grants administrator. This requirement will be detailed in a standard provision of the grant document.

2. Technical Status Report and Interim Products Report

Grantees will submit a technical status report on a quarterly basis and upon completion of the grant. These requirements will be documented in a standard provision of the grant document. Quarterly technical reports will be in narrative form and will summarize progress to date towards achieving the overall grant objectives and the intermediate benchmarks and towards completing the intermediate products that are due during quarterly reporting period.

The field office grants administrator will also ensure that all intermediate deliverables or grant products scheduled to be completed during the reporting quarter are received on time. The field office will review or request technical assistance in reviewing all intermediate products to ensure that they are technically sound.

C. Meeting with Grantees

The program field office grants administrator will meet directly with all grantees at least once during the first six months of the grant to provide feedback on the financial and technical reports, to review intermediate products and overall progress, to determine technical assistance needs and to determine if any modifications to the grant are anticipated. Additional meetings will be scheduled, based on the length of the grant and on the

adequacy of the financial and technical reports and intermediate grant products received during the first and/or second reporting quarter.

D. Technical Assistance Needs

The Program field office will coordinate all technical assistance needs for grant program activities.

E. Commodities Management

Title to property purchased with funds from the small grants program will vest in the grantee. Grantees will be required to report to the grants administrator the purchase of all items with an acquired value of $1,000 or more and the Program field office grants administrator will ensure that proper authorization from USAID is obtained for the purchase of any restricted or ineligible goods or for the use of unauthorized sources.

F. Payment of Grant Funds

1. Process

The method by which grant funds will be provided will be specified in a standard provision of the grant document. For grantees with an adequate accounting system, the Program field office will fund the grant through a series of incremental advances. A schedule of disbursements will be developed and included in the grant document. The number of subsequent disbursements will be determined by the overall amount of the grant and by the workplan. All subsequent disbursement(s) will be tied to the completion of an important interim benchmark.

2. Costs

Grant funds can be used to cover costs incurred during implementation of the grant activity, provided that they are incurred as a result of directly carrying out grant activities and are reasonable, allocable and allowable in accordance with terms of the applicable cost principles. These limitations will be specified in a standard provision of the grant agreement and the program field office will review all financial reports to ensure compliance with this requirement. Any costs found questionable by the field office will be referred to the USAID Contracting Officer to determine whether or not they are allowable. This procedure will be specified in a standard provision of the grant document.

G. Amending Grants

1. Funded Amendments

a. Process

Under very limited circumstances, grantees may be provided with additional funds over the amount originally obligated. To be considered for additional funding, a grantee must notify the Grants Administrator of the need for additional funding at least 30 days in advance of the date by which additional funds will be required. Additional funds will only be provided through a formal modification to the grant agreement and this procedure will be specified in a standard provision in the grant agreement.

b. Notification

The grantee will be required to advise the program 30 days in advance if additional funding will be required. This requirement will be specified in a standard provision in the grant agreement.

2. Non Funded Amendments

a. Process

All non-funded amendments to grant agreements will be made by an exchange of letters between the grantee and the program field office director. This procedure will be specified in a standard provision in the grant agreement.

b. Notification

The grantee will be required to advise the program 30 days in advance if a change in the scope or the objectives of the activity is required or if a change in the funding allocated among activity components or budget line items is required. Grantees will be allowed line-item flexibility of up to 25% and deviations in excess of this amount must be approved through a formal modification to the grant agreement. This procedure will be specified in a standard provision in the grant agreement.

H. Terminating Grants

1. Termination for Cause

The program field office grants administrator, in conjunction with the field office director and the program director, may determine during routine grant management that a grant should be terminated for cause because the grantee is unable to implement the activity in accordance with the terms specified in the grant document. Grants will only be terminated for cause after the grants officer and the grantee make at least one attempt to resolve implementation difficulties. The program's authority to terminate a grant for cause, and the criteria that will be used to make such a decision, will be specified in a standard provision of the grant agreement.

2. Termination for Convenience

The program grants officer or the grantee may determine during at any point during grant implementation that the grant should be terminated for convenience, in whole or in part. Grants will only be terminated for convenience after the program grants officer and the grantee agree that continuing the grant would not be productive. The program and the grantee's authority to terminate a grant for convenience, and the conditions under which such a decision would be made, will be specified in a standard provision of the grant agreement.

I. Notices

All notices given by the program or the grantee must be made in writing and delivered in person, mailed or cabled to the program grant officer or the grantee. This procedure will be specified in a standard provision of the grant agreement.

VI. **Grant Closeout Procedures**

A. Financial and Technical Reports and Accounting Records

All final financial and technical reports will be due within 90 days of the completion of the grant. The program field office will be responsible for ensuring the receipt of these reports.

All grantees will be advised of the requirement to keep all financial documentation and records associated with the grant for a period of three years.

B. Grant Activity Products

The Program field office and the grantee will meet to review and determine that all grant activities have been completed in accordance with those specified in the grant document. The program field office grants administrator will review all products required by the grant activity to verify that they are complete and of acceptable quality. The field office grants administrator will coordinate technical assistance, if necessary, to improve either the level of completeness or quality of grant activity products.

C. Budget Reconciliation

The Program field office will reconcile the grant budget with the grantee and ensure that the grantee refunds any balance of unobligated cash that the Program has advanced or paid and that is not authorized to be retained by the grantee. This procedure will be documented in a standard grant provision of the grant agreement.

The program will not reimburse he grantee for costs incurred in excess of the total amount obligated under the grant and this principle will be documented in a standard grant provision of the grant agreement.

D. Commodities

The Program field office will ensure that the grantee accounts for any property acquired with grant funds in accordance with the title provisions of the grant. Grantees will report to the field office the purchase of all property valued at more than $1,000. The field office will review the plan for the disposition of all items with value of more than $1,000 and will review and approve an inventory schedule and final disposition plan for all government property.

VI. Grant Evaluation

Individual grants and the entire grants program will be evaluated primarily on the basis of their contribution to the decision making process regarding health sector reforms in NIS. Although it is difficult to demonstrate the impact of research/demonstration programs, objective criteria which demonstrate that the grant results informed some specific decision regarding health sector reform will be identified.

APPENDIX G4

STANDARD DOCUMENTS CREATED

Standard Grants Announcement

Standard Grant Application Format

Instructions for Writing Grant Application

Standard Criteria for Evaluating Applications

Standard Grant Agreement

NIS HEALTH FINANCE, ORGANIZATION AND MANAGEMENT REFORM PROJECT

ANNOUNCEMENT OF SMALL GRANTS PROGRAM
AND
REQUEST FOR APPLICATIONS

Background

The Health Care Finance and Service Delivery Reform Project is sponsored by the United States Agency for International Development (USAID) and will design and evaluate innovate strategies for health financing and service delivery reform in the NIS. Over an initial period of three years, the project will use three main strategies to achieve its objectives. First, the Project will design and implement health financing and service reform programs in long-term intensive demonstration sites (IDS) and provide a broad range of technical assistance. The Project will also provide training for those participating in health care financing and delivery. Finally, the Project will implement and manage a small grants program to provide NIS-based individuals and institutions working within the health sector with opportunities to develop and test different reform strategies.

Grants Program Objectives

The objective of Project's small grants program is to provide funding for NIS-based institutions and individuals to design and implement innovative, experimental pilot projects that will have clear policy implications and that will demonstrate to NIS-based health personnel and AID how to improve or increase the financing, quality, efficiency, distribution and management of health services in the NIS. Grant activities in intensive demonstration sites will be complemented by technical assistance to NIS-based health institutions.

It is expected that most grants will fund experimental pilot projects that promote alternative approaches to health financing and health care organization and management. Some examples of activities include supporting the development of:

Alternative health care financing strategies such as cost recovery schemes, capitated health care, indemnity insurance and supplemental health insurance to augment the benefit package offered by the national health system.

Quality assurance and consumer advocacy organizations and initiatives in quality assurance, utilization review and cost containment systems.

Private health care services such as physician group practices, family practice clinics and private specialty services such as ambulatory care, diagnostic facilities and birthing centers, or feasibility studies to determine whether a private health service is a viable business venture.

A smaller number of grants will also support applied research and special studies that support the development of competitive markets.

A majority of grant funds will be used to support activities that either directly compliment or are related to the project's intensive demonstration site activities.

Grant funds will primarily be used to support costs associated with implementing a pilot project or research activity (stipends for salaried personnel or fees for local consultants) or with the provision of technical assistance for business planning, market studies, survey research or information systems development. Some materials and commodities and support costs for secretaries and data management will also be funded. Grant funds can also be used to support workshops, document preparation and publication and other dissemination activities.

Eligibility for Grant Awards

The small grants program will accept applications from and award grants to NIS-based individuals and institutions working in the health sector. Potential grantees include NIS-based businesses and industries engaged in commercializing their health facilities, private health service organizations, public health facilities and pharmacies involved in privatization, private insurance providers and research institutions.

Proposed activities should have clear implications for policy concerning improved accessibility, efficiency and quality of health care and should be financially viable so that if successful, the institution will be able to continue the demonstration activity after the grant ends. Although both of these criteria will be considered in making a grant award, proposals with excellent financial prospects that impact less on policy issues concerning improved accessibility, efficiency and quality of health care are eligible for funding as are proposals with very clear policy implications, that do not demonstrate strong prospects for financial viability. Ideally, activities funded should demonstrate strong potential for financial viability but in some cases may be too risky to obtain commercial financing.

Grants Program Limitations

Grants will not, in general, be awarded to support international travel or training, unless these activities represent a discrete, small component of the grant and are clearly necessary to achieve the overall grant objectives. Furthermore, grant requests that are primarily for purchasing commodities, supplies and other equipment will not be funded. Grants will not be awarded to NIS government entities or agencies.

Funding Level and Matching Agreement

Over the life of the project, the Grants Program will sponsor up to 50 different grants. The average amount awarded will be $50,000 per grant, although individual grant amounts may range from $10,000 to $100,000.

To maintain a business like approach to the grants program, grantees, in general, will be required to provide matching funds to support part of the costs of the proposed activities. The match may be a cash or an in-kind contribution. Grant program support should not exceed 75% of the total estimated cost of the activity.

Geographic Focus

Although the grants program will operate NIS-wide, it is expected that by the end of the project, approximately 60% of all grants awarded will be conducted in Russia, 25% of grants will be conducted in the Central Asian Republics and 15% in other NIS republics. In Russia and the Central Asian Republics, approximately 75% of all grants will either be conducted in one of the intensive demonstration sites or will otherwise directly support an intensive site activity. These percentages, however, represent project targets and the number of grants awarded during any one funding cycle (see below) to a particular geographic location or intensive demonstration site will vary.

Implementation Schedule

The Grants Program will award a majority of all grants during four separate funding cycles within the first two years of the project. A limited number of grants may be implemented during the third year. Grant award and implementation will be limited to specific funding cycles in order to limit the number of grants active at any one time to about 15 per project area. The first funding cycle will begin on May 15, 1994 and grants approved for this cycle will be awarded by July 15, 1994. The grants are expected to range in length from six months to 18 months. Additional funding cycles are scheduled for December, 1994, and January and July 1995.

Grants Program Agenda

Prior to each new grants award cycle, the Project will determine the agenda for the cycle that will list those reform related issues and questions for which proposals are being requested. Use of the agenda will ensure that all grant activities meet the key objectives of identifying reform-related policy options or implications and identifying innovations that are financially sustainable. The Project expects that by establishing a clear agenda for experimental projects, it will also ensure that the results of grant activities from individual funding cycles and from the overall grants program will complement each other and provide decision-makers in the NIS with the information and viable options they need to implement priority reforms. The Project will focus on the following agenda items for the first grant cycle: (Note: list is illustrative; to be finalized by grants committee with input from the field.)

What incentive-based payment mechanisms promote cost containment and quality improvement?

What alternative methods can health care providers use to promote efficiencies and service quality?

What are the impacts of privatization on service quality?

What are the impacts of new or changed medical practices on the efficiency and cost of health services?

What approaches increase patient self-responsibility in a reformed health system?

Application Requirements and Procedures

Individuals and institutions in the NIS are invited to submit applications for grant funding to the Project's office in Moscow or Almaty. To be considered for funding, grant applications must clearly address an issue on the grants agenda for the funding cycle, must be submitted in a format that corresponds to the standard grant application format provided by the Project and must be received by the deadline. The Project will provide an example of the standard application format, instructions for preparing a grant application and technical assistance for developing an application, as necessary, to individuals/institutions interested in applying for a grant.

The standard application format will include the following sections:

-A description of the individual's or the institution's experience in health care financing or service delivery

-A clear summary of expected outcomes

-The resources and activities required to meet the objectives and outcomes

-A realistic budget

-Clear benchmarks by which progress can be evaluated

-A plan for monitoring and evaluating the grant

-A plan for disseminating the grant activity's findings and results

Awarding and Implementing Grants

All applications will be evaluated by the Project's Grants Committee, using a set of standard criteria that will be available to all interested parties. Once an application has been selected for a grant award, the Project staff will work with the individual or institution to develop the Grant Agreement. The agreement will formalize the responsibilities of the grantee and the Project under the grant and will clearly outline the activity's purpose and objectives, the implementation schedule, the budget, and the expected outputs and products of the activity.

Prior to actually receiving grant funds, all grantees must demonstrate that their accounting system is adequate to show all costs incurred under the grant and that the grant funds can be managed separately from other individual or institutional funds. Grantees will be primarily responsible for implementing and managing all activities associated with the grant and for ensuring that the grant objectives are achieved. The Project will provide technical assistance for implementing grant activities, as necessary and as requested.

Grantees will be required to submit financial and technical reports on a quarterly basis that will summarize their progress in implementing the grant. Project staff will also meet with grantees on a quarterly basis to review the financial and technical reports, all interim grant products and progress towards overall grant objectives.

Contact Information (To be provided).

ZDRAV*REFORM* PROGRAM
GRANT APPLICATION FORMAT AND INSTRUCTIONS

Please submit your application to the Zdrav*Reform* Program Office in Moscow. Please use the outline presented in this document to prepare your application and to make sure to include information on all sections for which instructions are provided. These sections are identified by bold lettering. Applications which do not follow this format will not be accepted.

After the Zdrav*Reform* Program Office in Moscow receives your application, you will be notified that your application has been received. You will be notified by letter when the program has completed its review of all grant applications received for this funding cycle. The review process takes approximately two weeks.

If your grant application is not approved, you will be informed of the reasons.

If your application is approved, you will be contacted directly so that a meeting between your organization and the Zdrav*Reform* Program staff can take place. During this meeting, the scope of work, final budget and Grant Agreement Document for the grant activity will be negotiated.

Zdrav*Reform* Program - Moscow
Grants Manager
Moscow 117409
2 Leninsky Prospect
Floor 4A

Tel 7-(095)	956-78-17
	247-23-07
Fax 7-(095)	956-78-18
	247-23-08

I. **Executive Summary**

Please summarize your institution's goals and capabilities and the objective and expected results of the program you are requesting support for. Please describe the location where grant activities will be completed and the proposed beginning and end dates of the grant project.

II. **Organizational Capabilities**

A. **Background**

Please state the date your institution was formed, the institution's principle goals, functions and responsibilities, the numbers and categories of staff and the legal status (Please include a copy of any registration documents) .

B. **Previous Experience**

Please describe your institution's previous experience in completing services or activities that are similar to those you are proposing to conduct in the grant application. Specifically, list similar activities performed by your institution during the past three years. If similar work was conducted at the request of an organization or individual outside of your institution, please list a contact person, title, the name of the organization, a telephone number and the dates during which the activity was completed.

In this section, you may also list other references who can comment on your ability to complete the proposed activity.

C. **Key Personnel for Grant Project**

1) **Manager/Administrator**

Please describe the qualifications and experience of the individual(s) who will manage and administer the grant activities.

2) **Technical Director**

Please describe the qualifications and experience of the individual(s) who will provide oversight and management for the technical components of the grant activities.

3) **Other Key Staff**

Please describe the qualifications and experience of the individual(s) who will be responsible for conducting the activities that will be supported by grant funds.

D. **Financial Status**

Please provide background information on the financial status of your institution, including copies of your financial reports for the past three year period, if available, and reports from any audits of your institution that have been completed.

III. **Program Description**

Please describe clearly all important elements of the grant activity in this section. The logical linkage between the activity outputs and the achievement of project objectives should also be made clear.

A. **Project Rationale and Objective**

Please state the specific issue or research question on the ZdravReform Program's Grants Agenda that you are submitting an application for. Please describe your organization's understanding of why this issue is important and how the issue relates to the constraints and problems in financing, organization and management confronting the health sector.

Describe the project's main objectives. The objectives are the measurable results that are expected to be achieved by the end of the project.

B. **Expected Project Outputs and Results**

Please describe the specific outputs and results that will be produced by the activity. The activity results are what the project will accomplish and what the grantee will be responsible for delivering upon completion of the grant. Clearly describe how completing the project outputs and achieving the project results will accomplish the project objectives. The contents of this section will be included in the grant agreement document as the specific results that will be produced by the grant project, if the application is approved.

C. **Project Description** (Personnel Resources and Activities Required to Meet Project Outcomes)

Please describe the technical methods you will use to implement your project activities. Describe how you determined the technical or methodological (for research activities) approach to use.

Please also discuss why you believe that the solutions you will be testing under the grant can be replicated in other parts of Russia.

D. **Workplan and Timeline**

Please describe who among the project's key staff will complete each of the activities for each project output or result and how and when the activities will be implemented. The timeline should show when all major activities will take place, by month and year.

Please describe the activities that will be completed under the grant. If the project has more than one major output or result, please describe all of the activities needed to achieve each of the project outputs or results. Please list the staff who will implement each of the activities. The contents of this section will be included in the grant agreement document as the scope of work for the grant project, if the application is approved.

E. **Technical Assistance and Training Needs**

Please list the types of technical assistance and training that your institution will need to implement the grant activities.

Please describe the technical assistance and training that you will obtain using grant funds and list the individuals and organizations who will provide you with the technical assistance and training.

List any remaining needs for technical assistance and training that you will not be able to meet with grant funds and state whether or not you will request additional technical assistance from the ZdravReform Project to meet these needs.

F. **Plans for Sustainability**

Please describe how your institution will cover the costs of the project activities that will be supported initially by grant funds after grant funding ends.

Please describe how implementing the grant project and its activities will improve the managerial and technical skills of your institution's key staff and consultants who will implement the grant activities or how the grant project will improve the financial status of your institution.

G. **Plans for Communicating and Disseminating Results of Grant Activities**

Please describe how your institution will inform other individuals and organizations about the results of your grant activities and about how others can also implement the activities you have undertaken and replicate the results you have achieved.

IV. Grant Project Monitoring and Evaluation

In this section, describe your institution's plan for monitoring and evaluating the grant project.

Please describe what indicators you will use to measure progress in implementing each of the major grant activities, the dates when you will monitor each indicator, and the method you will use for monitoring.

Please describe what indicators you will use to evaluate the grant activity after it is completed. What criteria will you use to determine whether or not the activity was successful.

V. Budget

The budget should show the total estimated cost of the project from all sources, including those costs that will be covered by grant funds and those costs that will be covered by cash or in-kind matching funds provided by your institution. The estimated cost should be broken down for major budget categories and line items for each year of the grant and should clearly show what grant funds will be used for and what the cash or in-kind contributions from your institution will support. Budget line items should also be linked to the activities described in the activity workplan. Budget categories are represented below by a capital letter. Budget line items are the numbered components listed below the budget categories. Categories and line items include:

A. **Personnel**

Please list the salaries or wages for all staff who will be implementing grant activities. For each staff position, show the total number of hours or months and the percent of time that each staff person will spend working on grant activities.

B. **Consultants**

1) **Fees**

Please list all individuals who will be consultants on grant activities. Show the total number of hours or months that each consultant will work and the total fee that will be paid to each consultant.

2) **Travel and Per Diem**

Please list the total travel and per diem costs that will be incurred by consultants who will work on grant activities.

C. **Travel and Per Diem**

Please include all travel, per diem and other related travel costs for all staff personnel except consultants. Please show travel and per diem costs for in-country and foreign travel separately.

1) **Travel**

2) **Per Diem**

D. **Other Direct Costs**

1) **Operational expenses**

List all costs associated with the rental of the institution's operating facilities

2) **Materials production, publication and duplication**

List all costs for printing and reproduction

3) **Communications**

List all costs for postage and delivery and telephone, telex and fax charges

4) **Equipment and supplies (office, medical, other)**

List all costs for office equipment (typewriters, microcomputers, furniture, copiers, rentals and other project-related equipment needs.

5) **Supplies/Commodities**

List all costs for expendable items, including software, stationary, other office related products and commodities.

6) **Dissemination**

List all costs associated with the dissemination of the results and outputs of grant activities. Include the costs for materials, printing, reproduction and mailing the final reports and outputs of the grant activity. If you will conduct workshops or organize other meetings to present the results and outputs of the grant activity, include those costs here.

STANDARD CRITERIA FOR EVALUATING GRANT APPLICATIONS

I. Grantee Organizational Capabilities (25)

A. Integrity and previous experience of grantee institution (5).

1. Does the grantee/institution demonstrate a satisfactory record of integrity and business ethics and a satisfactory record of performance with respect to recent or current grants, contracts and cooperative agreements?

B. Financial Status and Key Personnel of grantee institution (20).

1. Financial Resources (10)

Most grant applications will include an appropriate cost sharing component. Does the grantee demonstrates that:

Adequate financial resources are available to provide the anticipated level of matching funds?

Its accounting, record keeping and overall financial management systems can or have the potential for meeting standards and practicing agreed upon methods of accounting for grant funds?

2. Key Personnel (10)

Do the manager, technical director and key staff proposed to complete the activity demonstrate a potential or actual level of technical and managerial expertise to ensure a reasonable likelihood for project success?

II. Grant Project Design (50 Pts)

A. Does the proposed activity and its objectives address a clearly defined grants agenda issue or question and does the applicant demonstrate an understanding of the major constraints and problems confronting the health sector? (5)

B. Does the application show clearly that the activity will build on previous experience and knowledge and show that by achieving its objectives, the project will demonstrate potential solutions that have clear implications for reforming health policies or implementation strategies? (10)

C. Are the proposed project outputs and results sufficient to achieve the project objectives? (5)

D. Are the proposed personnel resources and activities adequate to achieve the project objectives and results? Do the proposed activities have a reasonable chance of achieving the expected outputs or results? (10)

E. Is the proposed approach appropriate, on both technical and logistical grounds and is the approach replicable in other settings? (5)

F. Is the proposed timeline reasonable and is the sequencing of proposed activities appropriate? (5)

G. Does the proposal demonstrate that the organization can support project activities after grant funding ends? Will implementing the grant activities increase the technical and managerial capacity of the organization's staff? (5)

H. Are the proposed technical assistance and training needs appropriate to the organization's current technical and

managerial capacity and the overall set of skills required to implement project activities? (5)

III. Monitoring and Evaluation Plan (10)

A. Does the plan identify appropriate benchmarks and indicators for monitoring the implementation of grant activities and is the schedule of monitoring frequent enough to identify implementation problems and to ensure that activity implementation stays on schedule? (5)

B. Are the evaluation indicators and criteria consistent with the objectives of the activity? (5)

IV. Budget (15)

A. Are the proposed budget line items and amounts consistent with the resource requirements needed to implement the project activities and achieve the project results? (10)

B. Are the proposed individual budget line item amounts consistent with the current costs for the same or similar items and services (5)?

GRANT AGREEMENT
BETWEEN
ABT ASSOCIATES INC.
AND
(GRANT RECIPIENT)

ISSUED BY: Abt Associates Inc.
55 Wheeler Street
Cambridge, MA 02138
Telephone: (617) 492-7100
Fax: (617) 492-5427

Abt Grant Officer: John S. Tilney, Jr.
Abt Grant Administrator: Ellen R. Bobronnikov
Abt Associates, Inc.
117409 Moscow, Russia,
Leninsky Prospect 2
Telephone: (095) 956-78-17, (095) 247-23-07
Fax: (095) 956-78-18, (095) 247-23-08

GRANTEE:
Telephone:
Fax:
Grantee's Responsible Officer:

EFFECTIVE DATE:

ESTIMATED COMPLETION DATE:

GRANT AMOUNT:

OBLIGATED AMOUNT:

PRIME CONTRACT: U.S. Agency for International Development

CONTENTS: This Grant Agreement consists of the following:

Cover Page	
Article 1:	Schedule
Exhibit 1:	Grant Budget
Article 2:	Representations
Article 3:	General Provisions
Attachment A:	Program Description
Attachment B:	Payment Provisions
Attachment C:	Applicable A.I.D. Handbook 13 Provisions
Attachment D:	Applicable Cost Accounting Standards
Attachment E:	Reporting Forms and Instructions
Attachment F:	Summary of Foreign Corrupt Practices Act (FCPA)
Attachment G:	Applicable USAID Procurement Standards

GRANT AGREEMENT
BETWEEN
ABT ASSOCIATES INC.
AND
(NAME OF GRANT RECIPIENT)

WHEREAS, Abt Associates Inc. (hereinafter referred to as "Abt") has entered into a Prime Contract with the United States (U.S.) Government, Agency for International Development (hereinafter referred to as "Government" or "A.I.D." to conduct the **NIS Health Care Finance and Service Delivery Reform Program**, under Prime Contract No. CCN-0004-C-00-4023-00, and

WHEREAS, Abt hereby grants to (NAME OF GRANT RECIPIENT) (hereinafter referred to as "Grantee") the sum of $____ to provide support for a program in _____, as described in the Schedule of this Grant and Attachment A entitled "Program Description." If the Grantee does not have a foreign currency bank account, the equivalent sum in Rubles, calculated at the exchange rate of the Central Bank of the Russian Federation on the date of payment, will be granted. This grant is made on condition that the funds will be administered in accordance with the terms and conditions as set forth in this Grant Agreement and Attachments thereto which have been agreed to by your organization.

In consideration of the foregoing and the mutual promises contained in this Grant Agreement, Abt and the Grantee agree as follows:

ARTICLE 1: SCHEDULE

1.1 PURPOSE OF GRANT

The purpose of this Grant is to provide support for (title of program or project), as more specifically described in Attachment A entitled "Program Description."

1.2 REPORTING AND EVALUATION

The Grantee shall deliver to the Abt Grant Administrator the items specified in Attachment A entitled "Program Description" (if any) and items described below on dates specified:

Quarterly Financial Status Reports. Standard Form 269A (Short Form) shall be used for reporting purposes. Standard Form 269A is included in Attachment E, including definitions and instructions for financial record keeping and reporting requirements.

Quarterly reports are due no later than 30 calendar days after the close of each calendar quarter, except for the final quarter of the grant period. The final financial status report is due within 90 calendar days after the grant's completion date. One original and two copies shall be submitted to the Abt Grant Administrator at the NIS-based address specified on the Cover Page of this Agreement.

Technical Status Reports and Report on Interim Products. The report shall be in narrative form and will summarize progress to date towards achieving the overall grant objectives, progress towards achieving intermediate benchmarks and progress in completing intermediate products that are due during quarterly reporting periods. Reports are due on the same dates as the Quarterly Financial Reports and in the same quantities.

The Abt Grant Administrator shall make site visits as frequently as practicable to:

- Review program accomplishments;
- Review management and accounting/financial control systems; and
- Provide such technical assistance as may be required.

The Grantee shall be notified in advance of planned site visits, including proposed dates and names of other members of the NIS Health Reform Project Team who may accompany the Abt Grant Administrator or make the site visit on his behalf.

1.3 PUBLICATIONS AND MEDIA RELEASES

The Grantee agrees to acknowledge A.I.D. in all publications, videos or other information and media products funded or partially funded through this grant. The grantee agrees to state within the product that the views expressed by the authors do not necessarily reflect those of Abt or A.I.D. The acknowledgment should read as follows:

> "This Publication was made possible through support provided by the Division IHHR, Bureau for Europe and the Newly Independent States, U.S. Agency for International Development. The opinions expressed herein are those of the author(s) and do not necessarily reflect the views of Abt Associates Inc. or the U.S. Agency for International Development."

The grantee will provide the Grant Administrator with two copies each of all published works developed under the grant. The author or the grantee is free to copyright any books, publications, or other copyrightable materials developed in the course of this grant, but Abt and A.I.D. reserve and hereby are granted a royalty free, nonexclusive and irrevocable right to reproduce, publish or otherwise use and authorize others to use the work.

1.4 PERIOD OF GRANT

The effective date of this Grant is _____. The estimated completion date of this Grant is _____.

1.5 AMOUNT OF GRANT AND PAYMENT

A. Abt hereby obligates the amount of $_____ for the purposes of this grant. If the Grantee does not have a foreign currency account, the equivalent sum in Rubles, calculated at the exchange rate of the Central Bank of the Russian Federation on the date of payment, will be obligated.

B. The method of payment to be used for this Grant is *(advance payment or reimbursement, in accordance with applicability requirements contained in Attachment B).* The payment procedures are set forth in Attachment B.

1.6 FINANCIAL PLAN AND ALLOWABLE COSTS

A. The Grant Budget

The Grant Budget, including local cost financing items (if authorized), is presented in Exhibit 1, "The Grant Schedule." Budget categories are denoted by capital letters and line items of a given budget category are denoted by numbers. The Grantee may expend grant funds only for activities and items listed in the budget and must obtain *prior written approval* from the Abt Grant Administrator for expenditures from grant funds for any cost not included in the grant budget.

B. Revision of Grant Budget

The Grantee must request approval from the Abt Grant Administrator in writing 30 days in advance if any change among budget categories or line items is anticipated. Written approval alone, without a modification to the grant agreement, will be sufficient to permit the Grantee to exceed the amount budgeted for any given line item by 15%, provided that another line item within the same budget category is reduced by the same amount. The Grantee may also be given written approval to exceed the amount budgeted for any given budget category by 5%, provided that another budget category is reduced by the same amount.

The Grantee is also required to notify the Abt Grant Administrator in writing 30 days in advance if additional funding will be required to complete the grant activity. Abt will not be required to reimburse the grantee for costs incurred in excess of the total amount of the grant. The Grantee will not be required to continue performance under the grant or to incur costs in excess of the amount obligated under the grant.

C. Cost Sharing or Matching

The grantee agrees to expend from non-grant funds and/or commit to the project [on a dedicated basis] in-kind resources in an amount at least equal to the amount or percentage of the total expenditures under this grant specified in the grant schedule. Individual expenditures do not have to be matched, provided that the total expenditures incurred during the funding period are shared or matched in accordance with the agreed amount specified in the grant schedule.

The grantee agrees to the criteria for accepting grantee cash and in-kind contributions outlined in A.I.D. Handbook 13, page 4D-52 and to the specific procedures for establishing the value of in-kind contributions outlined in A.I.D. Handbook 13, pages 4D-53 and 4D-54. The accounting, audit and record provisions in A.I.D. Handbook 13, pages 4D-55 are applicable to this grant. A copy of relevant sections of A.I.D. Handbook 13 are provided in Attachment C.

If the grantee fails to expend non-grant funds in the amount or percentage specified in the grant schedule during a funding period, the total amount of grant funding provided during subsequent funding cycles will be reduced by a corresponding amount. If the grant has ended, the grantee agrees to reimburse Abt an amount equal to the difference between the agreed to amount of non-grant funds and the actual amount of non-grant funds expended by the grantee on grant activities.

Failure to meet the cost sharing requirements set forth in this section shall be considered a sufficient reason for termination for cause of this grant in accordance with Article 3.5.

D. Refunds

At the time this Agreement expires or is terminated, funds shall revert to Abt if: 1) Abt has obligated funds to the grant, but has not disbursed them to the grantee, or 2) Abt has advanced funds to the Grantee, but the Grantee has not expended them. Funds which the Grantee has obligated in legally binding transactions applicable to this grant will **not** revert to Abt.

Abt reserves the right to demand a refund from the Grantee of any amount which the Grantee did not spend in accordance with the terms and conditions of this Agreement. In the event that a final audit has not been performed prior to the closeout of this grant, Abt retains the right to a refund until all claims which may result from the final audit have been resolved between Abt and the Grantee. The grantee shall make the refund in full no later than 30 calendar days after receipt of a demand for a refund from Abt.

E. Allowable Costs

The Grantee shall be reimbursed for costs incurred in carrying out the purposes of this Agreement which are determined by the Abt Grant Administrator to be reasonable, allocable and allowable in accordance with the terms of this Agreement and the applicable cost principles in effect on the date of this Agreement included in Attachment D. *Reasonable* shall mean those costs which are generally recognized as ordinary and necessary and would be incurred by a prudent person in the conduct of normal business. *Allocable* costs shall mean those costs which are incurred specifically for this Agreement. *Allowable* costs shall mean those costs which conform to any limitations in the grant. Unallowable costs, direct or indirect, include but are not limited to the following examples: Advertising, bad debts, contingencies, entertainment, fines and penalties, interest, fund raising, investment management costs, losses on other awards, and first class air fare unless specifically approved. Public information service costs are unallowable as indirect costs.

Before incurring a questionable cost, the Grantee will obtain the Abt Grant Administrator's written decision on whether the cost will be allowable.

E.1 Air Travel and Transportation. The grantee will notify the Abt Grant Administrator of the proposed itinerary for each planned international trip financed by this grant, including the name of the traveler, the purpose of the trip, the destination and the dates of travel, at least two weeks before departure.

All air travel under this grant is to be made on U.S. flag air carriers to the extent service by such carriers is available. A U.S. flag air carrier is defined as an air carrier which has a certificate of public convenience and necessity issued by the U.S. Civil Aeronautics Board authorizing operations between the U.S. and/or its territories and one or more foreign countries. Use of foreign air carrier service may be deemed necessary if a U.S. flag carrier cannot provide the foreign air transportation needed, or if use of such service will not accomplish the grant's objectives. Travel and transportation on non-free world air carriers are not reimbursable under the grant. The availability and use of U.S. carriers will be determined by the Abt Grant Administrator in accordance with A.I.D. regulations in Handbook 13, and the grantee agrees to abide by the terms of travel specified by the Grant Administrator.

The grantee agrees to use grant funds to reimburse costs for travel and for the reasonable costs of subsistence, post differentials and other allowances paid to employees in an international travel status in accordance with the grantee's established policies and practices which are uniformly applied to similar activities of the grantee. The grantee agrees that the standard for determining the reasonableness of reimbursement for overseas allowances is the Standardized Regulations published by the U.S. Department of State, which will be provided to the grantee when applicable upon request.

E.2 Participant Training. Participant training under this grant will comply with the policies established in AID Handbook 10. Copies of this Handbook are available upon request.

E.3 Overhead Rates. If the grantee has an established overhead rate and overhead is included within the grant budget, an overhead rate shall be established for each of the grantee's accounting periods during the term of this grant. Pending establishment of a final rate, provisional overhead payments shall be at the rate, on the base and for the period shown in the Schedule of this grant.

The grantee, not later than 13 months after the close of each of its accounting periods during the term of this grant, shall submit to the Abt Grant Administrator a proposed final rate for the period,

together with supporting cost data. The grantee and the Grant Administrator will negotiate a final overhead rate for the accounting period and the grant agreement will be amended to specify the agreed upon final rate, the base to which the rate applies and the period for which the rate applies.

Any failure by the parties to agree on any final rate under this provision shall be considered a dispute and resolved in accordance with Article 3.6 of this Agreement.

F. Accounting, Audit and Records

To the extent possible, the Grantee shall maintain books, records, documents and other evidence relating to this grant agreement in accordance with generally accepted accounting principles formally prescribed by the United States, the cooperating country, or the International Accounting Standards Committee (an affiliate of the International Federation of Accountants) to sufficiently substantiate charges to this Agreement. Accounting records that are supported by documentation will at a minimum be adequate to show all costs incurred under this Agreement, receipt and use of goods and services acquired under this Agreement, the costs of the program supplied from other sources, and the overall progress of the program. The Grantee's records which pertain to the Agreement shall be retained for a period of **three years** from the date of expiration of this Agreement. The Grantee agrees to make available to Abt, upon request, such records, books and documents and these may be audited by Abt and/or its representatives.

If the Grantee receives U.S. $100,000 (or the equivalent sum in local currency if the Grantee does not have a foreign currency bank account) in any successive 12 month period under this Agreement, the Grantee agrees that it shall arrange for an audit of funds provided under this Agreement and of the financial statements of the organization as a whole. Abt shall select an independent auditor in accordance with the "Guidelines for Financial Audits Contracted by Foreign Recipients" issued by the AID Inspector General. A copy can be provided upon request. The Grantee agrees to make available to the auditor all of its financial records relating to the grant and to cooperate fully with the auditor's request for information. The audit shall be a financial and operational audit performed in accordance with such guidelines and in accordance with generally accepted government auditing standards issued by the Comptroller General of the United States. Audits shall be performed **annually**.

The audit report shall be submitted to Abt within 30 days after completion of the audit, but the audit shall be completed and the report submitted not later than 13 months after the close of the Grantee's fiscal year. The Abt Grant Administrator will review this report to determine whether it complies with the audit requirements of this Agreement. In cases of continued inability or unwillingness to have an audit performed in accordance with the terms of this provision, Abt will consider appropriate sanctions which may include suspension of all or a percentage of payments until the audit is satisfactorily completed.

ARTICLE 2: REPRESENTATIONS AND WARRANTIES

2.1 AUTHORIZED REPRESENTATIVE

The grantee represents and warrants that the signatory on its behalf is duly authorized and fully empowered to enter into this Grant Agreement.

2.2 WARRANTY AGAINST INFRINGEMENT OF CERTAIN RIGHTS

The grantee represents and warrants that its performance of this Grant Agreement will not infringe the copyright, patent, or other property right of

any other person, and Subcontractor agrees to defend, indemnify, and hold harmless Abt and A.I.D. from any and all liability which may arise from breach of this warranty.

2.3 DEBARMENT, SUSPENSION, AND OTHER RESPONSIBILITY MATTERS

The grantee represents and warrants that it and its principals are not presently debarred, suspended, proposed for debarment, declared ineligible or voluntarily excluded from covered transactions by any Federal department or agency and that it has not within a three-year period preceding this grant agreement been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain or performing a public transaction or contract under a public transaction, or the commission of embezzlement, theft, forgery bribery, falsification of or destruction of records, making false statements, or receiving stolen property. The grantee also acknowledges that it is not presently indicted for or otherwise criminally or civilly charged by a government entity with commission of any of the offenses listed in the preceding sentence and that it has not within a three-year period preceding this grant application had one or more public transactions terminated for cause or default.

2.4 COMPLIANCE WITH LAW

The grantee represents and warrants its compliance with all applicable U.S. and/or local laws, ordinances and regulations governing performance of this Grant Agreement, including but not limited to the U.S. Foreign Corrupt Practices Act (a summary of which is included as Attachment F).

ARTICLE 3: GENERAL PROVISIONS

3.1 PROCUREMENT OF GOODS AND SERVICES

The grantee may use its own procurement policies and practices for the procurement of goods and services under this grant, provided that they conform to A.I.D. requirements listed in A.I.D. Handbook 13. These requirements are listed in Attachment G.

3.2 TITLE TO PROPERTY

Title to all property financed under *this grant shall vest in the grantee*. The grantee agrees to use and maintain the property for the purposes specified in the grant schedule. If the grantee uses the property for purposes other than those of the grant or sells or leases the property, Abt shall be reimbursed for the cost of the property, unless the Abt Grant Administrator authorizes the grantee to use the funds from selling or leasing the property as program income. The amount of reimbursement shall be computed by applying the percentage of Abt participation in the cost of the original grant program to the current fair market value of the property. The grantee agrees to maintain a property control system which will permit the ready identification of all equipment. The property control system is subject to the approval of the Grant Administrator. The grantee agrees to report the purchase of all items with an acquired value of more than the equivalent of U.S. $,1000 in local currency at the time of purchase.

The grantee will, within 120 calendar days of the end of the grant, provide a list to the Grant Administrator of each item purchased with a value of the equivalent of U.S. $1,000 or more in local currency along with a detailed proposal of what the grantee intends to do with that property. The grantee agrees to use the property in the program for which it was acquired as long as needed, whether or not the program continues to be supported by Abt. When no longer needed for the original program, the grantee agrees to use the property in connection with any other programs funded by the United States government. If the grantee proposes to retain the property for purposes other than those of the grant activity, the grantee agrees to reimburse Abt for the cost of the property. The amount of reimbursement shall be computed by applying the percentage of Abt participation in the cost of the original grant program to the current fair market value of the property. The grantee agrees to dispose of the property in accordance with its proposal list submitted to Abt at the time the grant ends, subject to final approval of the Grants Administrator.

3.3 NON-ASSIGNMENT AND LOWER-TIER GRANTING/SUBCONTRACTING

The grantee shall not assign this Grant Agreement or sublet or subcontract the grant or assign the right to receive any payments coming due hereunder without prior written consent from the Abt Grant Officer.

3.4 AMENDMENT

This grant may be amended by formal modification to the basic grant document or by means of an exchange of letters between the Abt Grant Administrator and an appropriate official of the grantee. All modifications of any of the terms or provisions of this grant agreement shall require the signature of the Abt Grant Officer.

3.5 TERMINATION AND SUSPENSION

The Abt Grant Officer may terminate this Agreement for cause at any time, in whole or in part, upon written notice to the Grantee, whenever it is determined that the Grantee has failed to comply with any of the terms and conditions of the grant or this grant agreement.

Either the Grantee or the Abt Grant Officer may terminate this Agreement for convenience at any time, in whole or in part, if both the Grantee and the Abt Grant Officer agree that the continuation of the grant would not produce beneficial results commensurate with the further expenditure of funds. Both the Grantee and the Abt Grant Officer will agree upon termination conditions, including the effective date and, in the case of partial termination, the portion to be terminated. The Abt Grant Officer will document the decision to terminate the Agreement in a letter to the Grantee.

If at any time Abt determines, in conjunction with the United States Agency for International Development, that continuation of all or part of the funding for the grant program should be suspended or terminated because such

assistance would not be in the national interest of the United States or would be in violation of an applicable law, then Abt may, following notice to the grantee, suspend or terminate this grant in whole or part and prohibit the grantee from incurring additional obligations chargeable to this grant other than those costs specified in the notice of suspension during the period of suspension. If the situation causing the suspension continues for 60 days or more, then Abt may terminate this grant on written notice to the grantee and cancel that portion of this grant which has not been disbursed or irrevocably committed to third parties.

Upon receipt of a termination notice for any of the above reasons, the Grantee will take immediate action to minimize all expenditures and obligations financed by this grant and will cancel all unliquidated obligations whenever possible. Except as provided below, no further reimbursements will be made after the effective date of termination. The Grantee will, within 30 calendar days after the effective date of such termination, return to Abt all unexpended Abt funds which are not otherwise obligated by a legally binding transaction applicable to this Agreement. Should the funds provided by Abt to the Grantee prior to the effective date of termination of this grant be insufficient to cover the Grantee's obligations in the legally binding transaction, the Grantee may submit to Abt within 90 calendar days after the effective date of such termination a written claim covering such obligations. The Abt Grant Officer will determine if the amount to be paid by Abt to the Grantee under such claim is in accordance with the applicable cost principles.

3.6 DISPUTES

A. Except as otherwise provided in this Agreement, any item of disagreement arising under or relating to this Agreement not disposed of by mutual consent of the parties shall be decided by the Abt Grant Officer, who shall reduce his decision to writing and mail or otherwise furnish a copy thereof to the Grantee. The decision of the Abt Grant Officer shall be final and conclusive unless determined by a court of competent jurisdiction to have been fraudulent, or capricious, or arbitrary, or so grossly erroneous as necessarily to imply bad faith.

B. This Disputes clause does not preclude consideration of questions of law in connection with decisions provided for in the above paragraph; provided that nothing in this Agreement shall be construed as making final the decisions of any administrative official, representative, or board on a question of law.

3.7 INDEMNIFICATION

The Grantee shall defend, indemnify and hold Abt and its officers, agents and employees harmless against any liability, claim, damage, suit, or expense (including reasonable attorney fees) caused by the Grantee's acts or omissions, including without limitation, claims based on: (a) Grantee's infringement of a patent, copyright, trademark, or other intellectual property right; (b) bodily injury, death, or damage to property caused by Grantee; (c) Grantee's conflict of interest, fraud, or criminal conduct; (d) Grantee's noncompliance with applicable laws or regulations; (e) Grantee's noncompliance with financial record keeping and reporting requirements of the Grant; (f) Grantee's failure to compensate, or comply with any applicable labor standards, laws, or regulations with respect to grantee's employees, agents, or lower tier grantees; and (g) Grantee's breach of this Agreement, or any representation or warranty contained in this Agreement. The provisions of this section shall survive the expiration or termination of this Grant Agreement.

3.8 GOVERNING LAW

This agreement shall be deemed to be an Agreement made under, governed by, and construed in accordance with the laws of the Commonwealth of Massachusetts, United States of America, without resort to choice of law or conflict of law principles.

3.9 GRANT DOCUMENTS

All attachments which are referenced in this Agreement are hereby made a part of this Agreement and are herein called the Grant Documents. Grantee represents that it has examined the Grant Documents and certifies that it is fully qualified to fulfill the grant requirements.

3.10 INDEPENDENT CONTRACTORS

Nothing contained in this Agreement shall be construed to create a joint venture, partnership or agency relationship between the parties; the grantee has no authority to represent or bind either Abt or A.I.D. in dealings with third parties.

3.11 SEVERABILITY

If any provision of this Agreement shall be determined by any court of competent jurisdiction to be invalid or unenforceable, the remainder of this Agreement other than the portions determined to be invalid or unenforceable shall not be affected thereby, and each valid provision hereof shall be enforced to the fullest extent permitted by law.

3.12 CAPTIONS

The descriptive section headings of this Agreement have been inserted for convenience only and shall not be deemed to limit or otherwise affect the construction of any provisions thereof.

3.13 NO WAIVER

Failure to insist upon strict compliance with any of the terms, covenants, and conditions hereof shall not be deemed a waiver of such terms, covenants, or conditions, nor shall any waiver or relinquishment of any right or power hereunder at any one time or more times be deemed a waiver or relinquishment of such right or power at any other time or times.

3.14 ENTIRE AGREEMENT

This Agreement, together with all attachments and incorporated provisions, shall constitute the entire agreement of the parties, and supersede all previous and contemporaneous agreements or representations, whether written or oral.

3.15 NOTICES

All notices required or permitted to be given hereunder shall be sufficient if in writing and personally delivered or sent by mail or courier of facsimile addressed, as applicable, to the Abt Grant Administrator or to the Grantee's Responsible Officer at the addresses (fax numbers) specified on the Cover Page of this Agreement.

IN WITNESS WHEREOF, the parties have caused this Grant Agreement to be duly signed and executed with the intention of becoming legally bound thereby.

FOR ABT ASSOCIATES INC.

BY: _____
(signature)

_____
(typed name)

ITS DULY AUTHORIZED
REPRESENTATIVE

TITLE: _____

DATE: _____

(Seal)

FOR (name of grantee)

BY: _____
(signature)

_____
(typed name)

ITS DULY AUTHORIZED
REPRESENTATIVE

TITLE: _____

DATE: _____

(Seal)

ATTACHMENT A

GRANT PROGRAM DESCRIPTION

(attachment included in Russian version)

ATTACHMENT B.1

PAYMENT - PERIODIC ADVANCE*(June 1993)*

This provision is applicable when (1) the grantee has an acceptable accounting system, (2) the grantee has the ability to maintain procedures that will minimize the time elapsing between the transfer of funds and the disbursement thereof, and (3) the grantee's financial management system meets the standards for fund control and accountability required under the standard provision of this agreement entitled "Accounting, Audit, and Records".)

a) Period advances shall be limited to the minimum amounts needed to meet current disbursement needs and shall be scheduled so that the funds are available to the grantee as close as is administratively feasible to the actual disbursements by the grantee for program costs. Cash advances made by the grantee to secondary grantee organizations or the grantee's field organization shall conform substantially to the same standards of timing and amount as apply to cash advances by Abt to the grantee.

b) Abt funds shall not be commingled with other grantee owned or controlled funds. All funds received by the Grantee under this Grant Agreement must be deposited in a separate non-interest bearing bank account in the name of the grantee organization to be used exclusively for the handling of advances, reimbursements and expenditures associated with this Grant Agreement. The Grantee agrees that the signatures of at least two representatives of the Grantee Organization will be required in order to withdraw funds from the account.

c) Each quarter, after the initial cash advance, the grantee shall submit to the Abt Grant Officer, identified in the schedule voucher SF 1034, entitled "Public Voucher for Purchases and Services Other Than Personal," a copy of which is attached.

d) Each voucher shall be identified by the appropriate grant number and shall be accompanied by a report following the format of the Federal Cash Advance Status Report (W-245), a copy of which is attached.

ATTACHMENT B.2

PAYMENT - COST REIMBURSEMENT*(May 1986)*

(This provision is applicable to grants where the grantee does not meet the conditions for periodic advance payment.)

a) The grantee shall submit to the A.I.D. Controller an original of SF 1034, "Public Voucher for Purchases and Services Other Than Personal" on a monthly basis and in no event no later than on a quarterly basis. Each voucher shall be identified by the grant number and shall state total costs for which reimbursement is being requested.

b) A copy of SF 1034 is attached.

END OF STANDARD PROVISION

FEDERAL CASH ADVANCE STATUS REPORT
(Report Control No. W-245)

A. Period covered by ***this*** report: Period covered by the ***next*** report:

FROM: _____/_____/_____ (Month/Day/Year) FROM: _____/_____/_____ (Month/Day/Year)

TO: _____/_____/_____ (Month/Day/Year) TO: _____/_____/_____ (Month/Day/Year)

B. Cash Advance Use and Needs:

(1)	Cash advance on hand at the beginning of this reporting period	$_____
(2)	Check advance(s) received during this reporting period	$_____
(3)	Interest earned on cash advance during this reporting period	$_____
(4)	GROSS cash advance available during this reporting period *(Lines 1, 2, & 3)*	$_____
(5)	LESS interest remitted to Abt during this reporting period	$_____
(6)	NET cash advance available during this reporting period *(Line 4 minus 5)*	$_____
(7)	Total disbursements during this reporting period, including subadvances[1]	$_____
(8)	Amount of cash advances available at the end of this reporting period *(Line 6 minus 7)*	$_____
(9)	Projected disbursements, including subadvances, for the next reporting period[2]	$_____

(10)	Additional cash advance requested for the next reporting period *(Line 9 minus Line 8)*	$_____
(11)	Total interest earned on cash advance from the start of the grant to the end of this reporting period, but not remitted to A.I.D.	$_____
(12)	Total cash advances to subgrantees, if any, as of the end of this reporting period	$_____

---

[1]The grantee shall submit a cumulative detailed report of disbursements by BUDGET line item quarterly.

[2]The grantee shall attach a Summary, by BUDGET line item, of its projected disbursements for the next reporting period.

C. CERTIFICATION

The undersigned hereby certifies: (1) that the amount in paragraph B.9 above represents the best estimate of funds needed for the disbursement to be incurred over the period described, (2) that appropriate refund or credit to the grant will be made in the even of disallowance in accordance with the terms of the grant, (3) that appropriate refund or credit to the grant will be made in the event funds are not expended, (4) that interest, if any, accrued on the funds made available herein will be refunded to Abt, and (5) no funds or proceeds thereof were dispersed or otherwise appropriated or used in a manner that would violate applicable local of U.S. laws, including but not limited to the U.S. Foreign Corrupt Practices Act.

BY: _____
(Signature)

_____
(Typed Name)

ITS DULY AUTHORIZED REPRESENTATIVE

TITLE: _____

DATE: _____

D. BANK ACCOUNT

All funds received by the Grantee under this Grant Agreement must be deposited in a separate non-interest bearing bank account in the name of the Grantee organization to be used exclusively for the handling of advances, reimbursements and expenditures associated with this Grant Agreement. The Grantee agrees that the signatures of at least two representatives of the Grantee Organization will be required in order to withdraw funds from the account.

ATTACHMENT C

APPLICABLE A.I.D. HANDBOOK 13 PROVISIONS

(attachment included in Russian version)

ATTACHMENT D

APPLICABLE COST ACCOUNTING STANDARDS

(attachment included in Russian version)

ATTACHMENT E

REPORTING FORMS AND INSTRUCTIONS

(attachment included in Russian version)

ATTACHMENT F
SUMMARY OF U.S. FOREIGN CORRUPT PRACTICES ACT

This outline briefly summarizes the relevant scope of the United States ("U.S.") Foreign Corrupt Practices Act ("FCPA") of 1977, amended in 1988, and related regulations; it is for informational purposes only and is not intended as legal guidance.

1. GENERAL

The FCPA consists basically of a prohibition against U.S. persons engaging in bribery of foreign officials either directly or indirectly (through the nationals or entities of other countries). It is a violation of the FCPA if a U.S. company or individual corrupts and knowingly takes steps to offer, pay, give or transfer anything of value to a foreign official, political party, official of a foreign political party or candidate for foreign political office, in order to influence any action in the person's official capacity, or to induce the official to use his influence or to violate his lawful duty, so that the U.S. firm or individual may obtain or retain business. This same prohibition applies to the use of any intermediary who offers or pays such amounts to any of the foregoing people. Further, one cannot avoid "knowledge" (and application of the statute) by deliberately disregarding facts. Finally, even if a "sensitive" or "facilitating" payment does not violate the FCPA, it still may result in violation of other U.S. federal or state laws or laws of foreign countries in which the company is operating, such as currency restrictions.

2. EXCEPTIONS AND EXCLUSIONS

(a) "Grease" Payments

It is not prohibited under the FCPA to make any "facilitating" or "expediting" payment, the purpose of which is simply to expedite or to secure the performance of a "routine governmental action." Therefore, a so-called "grease" payment may be made to a foreign official of any status, but only if it is for "routine governmental action," defined to mean that which is "ordinarily and commonly performed without the exercise of discretion." This grease payment exclusion does not exempt payments for governmental actions that are the functional equivalent of the award or retention of business.

(b) Legality under Local Written Law

It is a defense under the FCPA to make payments which are "lawful under the written laws and regulation" of the local country.

(c) Reasonable and Bona Fide Expenditures

It is also a defense under the FCPA to make payments that re directly related to the promotion, demonstration, etc. of products or services, or the execution of an existing contract with a foreign government (such as for travel and lodging expenses).

3. PENALTIES

The maximum fine for a U.S. corporation is two million dollars and one hundred thousand dollars for individuals found to have violated the statute. If criminal charges are pursued, the possibility for imprisonment is for a period of five years. Additionally, a civil penalty of ten thousand dollars per violation may be imposed on corporations and individuals by the Department of Justice. Further, an individual corporate employee may be convicted even if the U.S. corporation has not been found to have violated the FCPA. Finally, a violation of the antibribery provisions of the FCPA may result in a U.S. government-wide suspension or debarment from participation in American-funded programs.

ATTACHMENT G

APPLICABLE A.I.D. HANDBOOK 13 PROVISIONS PROCUREMENT OF GOODS AND SERVICES

I. The grantee shall maintain a code or standards of conduct that shall govern the performance of its officers, employees or agents engaged in the awarding and administration of contracts using grant funds. Conflicts of interest situations involving employees, officers or agents or their immediate families shall be avoided. The grantees officers, employees or agents shall neither solicit nor accept gratuities, favors or anything of monetary value from contractor or potential contractors. Such standards shall provide for disciplinary actions to be applied for violations of such standards by the grantees' officers, employees or agents.

II. The grantee agrees that all procurement transactions shall be conducted in a manner to provide, to the maximum extent practical, open and free competition. The grantee should be alert to organizational conflicts of interest or non-competitive practices among contractors that may restrict or eliminate competition or otherwise restrain trade. In order to ensure objective contractor performance and eliminate unfair competitive advantage, contractors that develop or draft specifications, requirements, statements of work, or requests for proposals should be excluded from competing for such procurements. Awards shall be made to the offeror whose offer is responsive/responsible to the solicitation and is most advantageous to the grantee, price and other factors considered. Solicitations shall clearly set forth all requirements that the offeror must fulfill in order to be evaluated by the grantee. Any and all offers may be rejected when it is in the grantee's interest to do so.

III. The grantee shall establish procurement procedures to meet the following requirements:

A. Procedures to assure that no unnecessary items are purchased.

B. Solicitations for goods and services will be based upon a clear and accurate description of the technical requirements for the material, product or service to be procured. Such a description shall not, in competitive procurements, contain features which unduly restrict competition.

C. The type of procurement instrument used (fixed price contract, cost reimbursable contract, purchase order, incentive contract) will be determined by the grantee but must be appropriate for the particular procurement and for promoting the best interest of the program involved. In those instances where a cost type contract authorizes a fee, a fixed amount will be used in lieu of a percentage of cost.

D. Contracts shall be made only to responsible contractors who possess the potential ability to perform successfully under the terms and conditions of a proposed contract. Consideration will be given to such matters as integrity, record of past performance, financial and technical resources or accessibility to other necessary resources. Contracts shall not be made to firms or individuals whose name appears on the "List of Parties Excluded from Federal Procurement and Nonprocurement Programs." Abt Associates will provide the grantee with a copy of this list upon request.

E. All proposed sole source contracts or where only one proposal is received in which the aggregate expenditure is expected to exceed $10,000 shall be subject to prior approval by an appropriate official within the grantee's organization.

F. Some form of price or cost analysis should be made in connection with every procurement action. Price analysis may be accomplished in various ways, including the comparison of price quotations submitted, and market prices, together with discounts. Cost analysis is the review and evaluation of each element of cost to determine reasonableness, allocability and allowability.

G. Procurement records and files for purchases in excess of $10,000 shall include the following:

1. Basis for contractor selection
2. Justification for lack of competition when competitive offers are not obtained
3. Basis for award, either cost or price

H. A system for contract administration shall be maintained to ensure contractor conformance with terms, conditions and specifications of the contract, and to ensure adequate and timely follow-up of all purchases.

IV. The grantee agrees that each contract and subcontract it issues will contain, in addition to provisions to define a sound and complete contract, the following contract provisions as well as any provision within the grant agreement which requires such inclusion of that provision in all contracts and subcontracts issued by the grantee. Whenever a provision is required to be inserted in a contract under this grant, the grantee shall insert a statement in the contract that in all instances where Abt Associates is mentioned, the grantee's name shall be substituted.

A. Contracts in excess of $10,000 shall contain contractual provisions or conditions that will allow for administrative, contractual, or legal remedies in instances in which contractors violate or breach contract terms, and provide for such remedial actions as may be appropriate.

B. All contracts in excess of $10,000 shall contain suitable provisions for termination by the grantee including the manner by which termination will be effected and the basis for settlement. In addition, such contracts shall describe conditions under which the contract my be terminated for default as well as conditions where the contract may be terminated because of circumstances beyond the control of the contractor.

C. All negotiated contracts over $10,000 awarded by the grantee shall include a provision to the effect that the grantee, Abt Associates or their duly authorized representatives, shall have access to any books, documents, papers and records of the contract which are directly pertinent to the specific program for the purpose of making audits, examinations, excerpts and transcriptions.

D. In all contracts for construction of facility improvement awarded for more than $100,000, the grantee shall observe generally accepted bonding requirements.

E. Contracts, the principal purpose of which is to create, develop or improve products, processes or methods; or for exploration into fields that directly concern public health, safety or welfare, or contracts in the fields of science or technology in which there has been little significant experience outside of work funded by Federal assistance, shall contain a notice to the effect that matters regarding rights to inventions and materials generated under the contract are subject to the regulations included in these grant

provisions. The contractor shall be advised as to the source of additional information regarding these matters.

V. The grantee agrees not to purchase, under any circumstances, the following ineligible and restricted goods and agrees not to purchase goods or services from ineligible suppliers:

A. Ineligible Goods and Services include military equipment, surveillance equipment, commodities and services for support of police or other law enforcement activities, abortion equipment and services, luxury goods, gambling equipment, weather modification equipment.

B. Restricted goods include agricultural commodities, motor vehicles, pharmaceuticals, pesticides, rubber compounding chemicals, used equipment, U.S. Government owned excess property, fertilizer.

C. Ineligible suppliers include any firm or individual whose name appears on the "Lists of parties Excluded from Federal Procurement and Nonprocurement Programs". Abt Associates Inc. will provide the grantee with this list upon request.

If Abt Associates Inc. determines that the grantee has procured any of these items or procured supplies from ineligible suppliers and has received reimbursement for such purposes, the grantee agrees to refund to Abt Associates Inc. the entire amount of the reimbursement.

VI. The grantee agrees that all goods and services, excluding computer equipment procured under this grant will be manufactured in the United States or Russia, unless one of the following conditions makes it unreasonable to procure an item of United States or Russian manufacture:

A. The procurement is of an emergency nature which does not allow for the delay that would be associated with procuring an item manufactured in the United States or Russia.

B. The price difference for procuring the item from a United States or Russian manufacturer exceeds by 50% or more the delivered price from a non-United States or a non-Russian manufacturer.

C. The goods or services to be procured are not available from a United States or a Russian manufacturer.

If the grantee procures an item of non-United States or non-Russian manufacture, based on one of the above mentioned conditions, the grantee agrees to document its files to justify each such instance. The documentation will describe specific details about the condition being cited to justify the procurement.

VII. The grantee agrees that all computer equipment procured under this grant will be of American brand name. American made computers include IBM, Compaq and Hewlett Packard.

APPENDIX G5

DESCRIPTION OF COMPETITION PROCEDURES AND SELECTION CRITERIA

Appendix G5: Description of Competition Procedures and Criteria for Selection for Health Sector Leadership Development Competition

August 18, 1995

Thank you to all of you for your participation on the Health Sector Leadership Development grants selection committee. Your expertise is greatly appreciated, and I look forward to working with you.

This packet of materials contains:

1. Schedule and itinerary of meetings
2. Grant announcement
3. Standard grant application format
4. First round evaluation sheets
5. List of all proposals received (in English only)
6. "About ZdravReform"

We have 57 proposals to review and twelve recipients to select. This is a daunting task, but I have tried to divide up the work yet maintain a fair competition. There are eight people on the committee, and we will divide up into teams of two. The teams are as follows:

1. Jim Rice
   Tamara Sirbiladze
2. Katya Grishnova
   Chris Ebner
3. Peter Mahoney
   Murat Vasin
4. Olga Triyanina
   Karen Martin

In the first round, each team will read approximately 14-15 proposals. The Russian counterpart will receive the original Russian language proposal along with all of the additional information provided. The American counterpart will receive the English translation of the proposal. It will be the responsibility of each team to meet and review the additional information as needed.

Each committee member will read all 14-15 proposals assigned to his or her team. Each person should fill out the first round evaluation sheet for each proposal and determine his or her top five choices based on the top five scores. Each committee member should then meet with his or her counterpart and discuss the proposals prior to the second meeting on August 31. After discussion, the team should decide which five proposals it will recommend for the second round. The teams should call me on August 30 and tell me which proposals they will recommend. Each team's decision will be announced at the meeting on August 31. At the meeting, each team must explain why a proposal was either accepted or rejected and provide brief written comments (on the evaluation sheets) about each.

An additional step may be added here. If any team decides that their top five choices require more information in order to make a better decision, the next meeting, now scheduled for September 7, will be delayed a couple of weeks. These weeks will be used to contact the twenty semi-finalists and collect the additional information.

Once each team has determined its top five proposals (and, if necessary, additional information has been collected), those twenty proposals will be distributed to each committee member. All committee members will read all twenty proposals and evaluate them based on the second round evaluation sheet (to be distributed August 31). Based on the top scores, each person should determine their top twelve proposals which they will recommend for funding. Each committee member will announce his or her top twelve proposals during the last meeting, tentatively scheduled for September 7. Scores will be tallied, and discussion will follow. During this last meeting,

the recipients of the grants as well as the sum to be awarded will be determined. The grant can range between $25,000 and $75,000.

If you have any questions during the review process, please feel free to contact me at any time. The ZdravReform office numbers are: 956-78-17, 247-23-07, 230-45-71, and 230-45-73. Again, thank you for your time and help.

Sincerely,

Karen Martin
Grants Manager

Committee Schedule

August 18 **First meeting**
11:00 am - introductions
- distribute proposals
- discuss criteria

August 30 **Member of each team should call Karen Martin and give list of top five proposals.**

August 31 **Second meeting (at ZdravReform office)**
10:00 am - discuss each committee's recommendations
- determine top twenty proposals
- determine whether more information is needed from the applicants
- collect first round evaluation sheets
- distribute second round evaluation sheets

Sept. 7 **Third meeting (at ZdravReform office)**
10:00 am - tally scores of all committee members
(tentative) - discuss proposals and determine sum of each grant

Name and Number of Proposal: _____

Name of Reviewer: _____

Criteria **Rate on scale of 1-10**

1. How well does the proposed project focus on the development of future leaders for health sector reform?

Comments:

2. How clear are the objectives of the project?

Comments:

3. Will project be sustainable beyond the life of the grant?

Comments:

4. How likely is it that measurable results will be evident in 9-15 months?

Comments:

5. Does the proposed project coincide with and/or contribute to the sample activities listed in the announcement?

Comments:

6. Does budget seem reasonable and appropriate for proposed work?

Comments:

7. Can organization be expected to be well managed and financially stable?

Comments:

Additional comments:

TOTAL SCORE (out of 70 possible): _____

APPENDIX G6

ESTABLISHING A NEW GRANT

Appendix G6: Establishing a New Grant

1. **Seek concurrence from USAID**. After grant selection committee has recommended that a particular organization receive a grant, the proposals and a memo asking for concurrence is sent to the USAID contracts officer (Susan Cheney-O'Byrne). The winning proposals should also be send to Bethesda so they are aware of the decision.

2. **Notify new grantee**.

3. **Conduct pre-award audit and assessment.** The new grantee should provide documentation regarding the organization's bookkeeping. A letter from an accountant certifying the records are in order is sufficient. In addition, either a phone interview should be conducted or the new grantee should fill out a checklist in order to show the grantee has acceptable management and personnel procedures in order to properly administer the grant. (See Small Grants Management Manual for additional details.)

4. **Begin grant agreement development**.

   Program Development (see Attachment A in any grant agreement)

   The project description as written in the proposal must be clarified and, in most cases, condensed into a clear, step-by-step project schedule. The following sections must be included in the grant program description: 1. Background and Rationale for Grant 2. Workplan and Schedule 3. Indicators for Monitoring Grant Program Implementation 4. Documents That will Be Produced Under the Grant Program. At this point, technical experts should be consulted to ensure that the program, as described in the grant agreement, is technically feasible and desirable.

Budget Development

Most budgets as described in the proposals are not sufficiently detailed and often lack a cost matching component. Following are several key points to keep in mind while writing the budget.

1. Grantee must contribute 25% of total grant funds. See Attachment C in the standard grant agreement to determine what can be included under cost matching. For example, cost matching can be in-kind, such as providing personnel, office space, and computers.

2. Salaries can be paid to people working on the grant as long as they are receiving their salary solely from grant funds. In other words, they cannot continue to receive a salary from their job they had prior to the grant. The only way they can retain their old job and receive a full salary from the grant is if they obtain an official leave of absence document from their employer. This is usually very difficult, so the other option is to pay people to work on the grant in their spare time. This means they can be paid 20% of full time. For example, if it is determined that the monthly salary should be $300, they can be paid $60 per month to work on the grant. Otherwise, they can be paid as a consultant at a daily rate for a set number of days under the grant (again, time not to exceed 20% of full time or 3-4 days per month).

Daily rates for Russian nationals working under the grant should not exceed $50/day and should, in fact, be well under this figure. Rates, in principle, should be based on current salary figures.

Direct payment to foreign consultants should be avoided since it has proven to be very difficult to pay the consultants in dollars.

The budget should be detailed. Every sum must be explicitly explained. If money is going for salaries, the sum must be broken down for each position, for example. Travel must be broken down into tickets, visa expenses, per diem, etc. (See Exhibit 1 of Attachment A.)

5. **Write task order**. Once the grant agreement is finished, a task order must be written and signed by the grants manager, regional director, and contracting officer at USAID (see example). The finance officer will write the budget for the task. This task order must be signed before the grant agreement is signed. A copy should be send to Bethesda.

6. **Write negotiation memorandum**. This memo should include explicit information about the competition, from the time of the announcement to the choosing of the grantees, as well as specific information about the new grantee, including the subject of the project, results of the pre-award audit, and how the grant agreement was negotiated.

7. **Sign agreement.** Send negotiation memorandum, signed task order, proposal, and grant agreement to John Tilney for his signature. He will fax back the signature page which the grants manager can countersign during a signing ceremony.

8. **Sign agreement with grantee**. Give grantee any additional materials about administering the grant, including information about when financial and technical reports are due. Offer to provide grantee with letter from USAID asking the Russian government to exempt the grantee from taxes on this sum. Get bank account information. (Make sure grantee has a separate account only for grant funds.)

9. **Transfer funds**. Write a letter to the finance officer requesting transfer to the new grantee. There is usually one transfer to a grantee per quarter, so amount transferred should be enough to cover 3 months of grant work.

APPENDIX G7

PRE-AWARD AUDIT AND ASSESSMENT

Appendix G7: Pre-Award Audit And Assessment

Please have your accountant respond to the questions below and send the form back to us as soon as possible.

1. Grantee maintains books, records, program documentation and other materials related to the grant in accordance with generally accepted accounting principles. Grantee accounting records are, at a minimum, adequate to show all costs incurred under the grants and the receipt and use of goods and services acquired under the grant. (A letter from an independent accredited auditor within the past year is sufficient.)

2. Grantee accounting and banking system can maintain grant funds separately from all other funds.

3. Grantee systems are adequate to maintain all documentation for a three year period.

4. Grantee has an adequate record system for property control and an adequate program for the maintenance of property.

5. Grantee has adequate financial resources to complete the grant activity and to provide the required level of matching funds.

6. Grantee has an adequate record of performance, integrity and management competence with respect to planning and implementing programs.

7. Grantee has the ability to complete the grant program, given all existing and prospective commitments.

8. Grantee has an overall eligibility to receive a grant award.

APPENDIX G8

SUMMARY OF REPORTS AND PROCEDURES GIVEN TO GRANTEES AFTER CONTRACT SIGNING

Appendix G8: Summary of Reports and Procedures Given to Grantees After Contract Signing

REPORTING RESPONSIBILITIES

Technical Reports

Monthly Summaries

At the end of every month, please submit a short, one page summary of your program's activities for the past month and intended activities for the next month. This summary should include primarily information about the technical aspects of your program rather than financial, since you will be submitting quarterly financial reports. In this summary, you may also include any questions or problems you would like the grants manager to address. This summary need not be extremely detailed. It is simply a way to keep the grants manager updated and aware of your progress.

Quarterly Technical Report

The quarterly technical report is due once a quarter along with the quarterly financial report. The report is due **no later that 30 days after the end of the quarter. Quarters end December 31, March 31, June 30, and September 30**. This report should summarize the program activities completed during the quarter, report on progress of each stage as described in the grant agreement program description (Attachment A), and include any documents which may have been completed during the quarter (draft legislation, agreements, etc.). For more information, see Article 1.2 of your grant agreement.

Financial Reports

Quarterly Financial Report

The quarterly financial report is due once a quarter along with the quarterly technical report. The report is due **no later than 30 days after the end of the quarter. Quarters end December 31, March 31, June 30, and September 30**. The quarterly financial report includes:

1. Completed form 269A (found in Attachment D of your grant agreement)
2. Completed form 1034 (found in Attachment B of your grant agreement)
3. Completed form W-245 (found in Attachment B of your grant agreement)
4. A letter which details items purchased or salaries paid in the previous quarter according to specific line item in budget, requests an additional sum of money for the next quarter, and details intended disbursements in the next quarter according to specific line item

Money Transfers

Generally, funds will be transferred once a quarter to your organization. Upon receipt of your quarterly financial report (see preceding section), the grants manager will process a wire transfer for the amount indicated in your letter and form W-245. Wire transfers take approximately two to three weeks to process after receipt of the request.

In the event your organization requires funds in the middle of the quarter, please submit a letter of request for additional funds. This letter should

include how the past money transfer was spent and according to which budget item along with how the additional sum will be spent and according to which budget item.

Final Reports

At the end of the grant period, all documents detailed in Attachment A of your grant agreement under "Items to Be Produced Under the Grant" are due, unless otherwise stated.

In addition, final technical and financial reports are required. The financial report should include a list of all items purchased with a value of the equivalent of $1,000 USD or more along with a detailed proposal of what the grantee intends to do with the property (see Article 3.2 of your grant agreement). The financial report should also include a detailed list of all disbursements not included in previous reports.

Please contact the grants manager for additional information upon completion of the grant.

MONITORING AND ADMINISTERING THE GRANT

Please read your grant agreement carefully. The following information highlights some of the most important points regarding administration of the grant. Most of this information can be found in your grant agreement. Contact the grants manager if you have any questions.

Time Sheets

Monthly time sheets are to be maintained for each person paid by grant money. The time sheet should include the name of the individual, detailed list of each day worked and how many hours worked on that day.

Receipts

Receipts are to be maintained in your files for any item over USD $25. **In the case of an audit and evaluation by USAID, you must have all receipts, time sheets, bank account statements and financial information properly documented and filed.** See Article 1.6F of your grant agreement.

Bank Account

Grant funds must be kept in a **separate** bank account designated for grant purposes only. Please provide the grants manager with your account information for money transfers.

Procurement

Any item purchased with grant funds must either be locally or American-made. If you must buy a non-local or American item, please provide the grants manager with a letter explaining why the local or American item was unavailable or undesirable in that particular circumstance. For additional information, see Attachment F of your grant agreement.

Several estimates should be obtained for any purchase. See Attachment F of your grant agreement.

Travel

All air travel must be on either local or American carriers. See Article 1.6D of your grant agreement.

APPENDIX G9

PROCEDURAL GUIDE FOR ORGANIZING STUDY TOURS

Appendix G9: Procedural Guide for Organizing Study Tours

The purpose of this study tour guide is to document the logistical procedures for organizing study tours to foreign countries. This document is intended to simplify study tour guidelines and to share some of the experiences that Abt Associates has gained from organizing a variety of study tours in the past. Below is a list of guidelines that should make the task of organizing study tours an easier process.

1. HEALTH INSURANCE

It is USAID policy that all training participants in the U.S. must be enrolled in USAID's Health and Accident Coverage (HAC) program. Cost for HAC Coverage per participant is $100 for the first full or partial month of the tour, a $100 for the last full or partial month of the tour, and $200 for all other months. If the entire tour occurs within a calendar month, the premium due for each participant is $100. If the tour overlaps into a second month, the fee per participant is $200.

Information that should be included in the payment include:

1. List of participant names;
2. Professional title;
3. Date of birth;
4. Marital status,
5. The period the delegates will be in the US for HAC coverage.

It is USAID policy that study tour delegates visiting third countries are not eligible to participate in the HAC program, but must be insured by a comparable program. In the past, Abt Associates has used an insurance company, called Gateway International, through its agent, Seabury & Smith, to purchase worldwide health insurance for participants while they are on a third-country study tour. A plan summary of this insurance is attached (Attachment H). Gateway International offers $25000 and $100,000 medical benefit policies at $3.00 and $4.00 per individual, under the age of 70, per day respectively for a minimum period of 15 days per person.

2. MEDICAL EXAMINATION

Before the issuance of Visas and HAC (Health and Accident Coverage) insurance for study tour participants, it is required that each delegate undergo a standardized medical examination. The purpose of the examination is to determine adequate health of the delegates for the training, ensure that the delegates will be able to contribute from what has been learned during the study to development of his or her country, and to minimize HAC costs.

The Medical Examination and Certification Form is the form that documents the medical examination. This form will be sent to you separately by the Grants Manager. The participant should complete from number 1 through 13 of the form, the examining physician should complete numbers 15 through 30, and the mission officer from USAID should complete the last page of the form.

3. VISA

It is USAID policy that delegates of USAID-funded study tours be admitted to the United States only under the USAID J-1 visa. The Certificate of Eligibility for Exchange Visitor (Attachment D), also known as the IAP 66A, is the application for the USAID J-1 visa. The Mission is responsible for tight controls of these visa forms.

4. THIRD COUNTRY APPROVAL

It is USAID policy to encourage participant training programs such as study tours to occur in the U.S. unless visiting a third country has greater development value or is more cost effective. It is USAID policy that Only USAID can grant exceptions to training in a non-approved country.

A waiver should be in the form of a memorandum and should include the following information:

1. Relevance to USAID project goals;
2. Justification of need for training;
3. Language Proficiency;
4. Non-availability of similar training in the U.S.; and
5. Non-availability of funding from country where training is to take place.

5. AIRLINES

U.S. carriers must be used for air transportation whenever available. Foreign carriers may only be used if a particular route is not served by a U.S. carrier. For Abt Associates to be reimbursed for airline costs, it is necessary to properly document all airfare tickets. The last page (stub) of the round-trip ticket, which documents the entire flight itinerary, should be saved with all other receipts pending request from Abt Associates or U.S. government organization.

6. PER DIEM

Per Diem is the daily allowance for lodging as well as meals and incidental expenses (M&IE) for each participant and traveling tour staff. Maximum Per Diem Rates for each city around the United States are published annually. These are the same rates used by Abt Associates staff and consultants when traveling. In this system, Abt Associates can only be reimbursed for the actual lodging costs that is equal to or under the allowed per diem cost per city. Delegates are allowed to use the total maximum daily meals and incidental expense (M&IE) per diem for each city as specified in their contract, but not to exceed the published maximum amounts.

7. ISSUING ADVANCE FOR MEALS AND OTHER TRAVEL COSTS

Study Tour participants who will be in the Boston or Washington DC areas may receive advance payment in the United States from our home offices for lodging, meals, and other travel costs. Based on the per diem discussion in **Section 8**, the participants must calculate the amount of advance money each delegate should receive for the duration of the tour. The participants must submit a budget documenting foreseen costs as specified in the budget of the contract to the Grants Manager in Moscow. This will be sent to Abt's home offices with a request to provide the participants with the advance when they arrive in the United States. However, it will still be necessary for all participants to bring a sufficient amount of cash to be used until the advance payment is received.

8. PARTICIPANT TAXES

Under federal tax law and current Internal Revenue Service (IRS) regulations, tax filings should be prepared for each training participant whether the delegate is exempt or not exempt from paying taxes. (Russian trainees & researchers are exempt up to 5 years with no maximum ceiling). Income, for tax purposes, is defined for participant training activities as the sum of all line-item training cost expenditures except for the administrative fees associated with the training activity. The total of study tour costs less administration expenses divided by the number of participants in the delegation will be the income for each participant in a study tour. Each participant must complete and sign the W-4 form and Claimed Abode Test Certificate.

GRANT STUDY TOURS
CHECKLIST OF PRE-DEPARTURE RESPONSIBILITIES

All USAID regulations as stated below must be met when travel is fully or partially funded by USAID. Refer to "Procedures Guide for Managing Study Tours" for more detailed information. Please contact Grants Manager (Ellen Bobronnikov or Yulia Solovieva) with any questions

___ Inform Zdrav*Reform* Grants Manager of tour details: names of delegation and leader, site/s to be visited, date/s, name and phone of U.S. contact/s.

___ Send name, gender, professional title, date of birth, marital status of each participant to Grants Manager, for USAID Health and Accident Coverage (HAC).

___ Complete medical examination and attached Medical Examination and Certification Form. The participant should complete from number 1 through 13 of the form, the examining physician should complete numbers 15 through 30. This is required for HAC and for J-1 visa.

___ J-1 visas are required for all travel to the United States on USAID funded training program. In order to receive a J-1 visa, you must bring or send to Grant Manager at least 4 weeks in advance of your trip the following for each participant:

* Original Passport
* 3 passport photographs
* Completed Medical Examination Form (see above)
* Signed Training Regulations
* Biographical Form
* Visa Application Form

___ Participants must travel on U.S. airlines. Foreign carrier should only be used if a particular route is not served by a U.S. carrier.

___ Send copy of flight itinerary to Grants Manager.

___ Verify scheduled departure; inform Grants Manager of delay or non-departure.

Appendix 3: List of Russian Experts Engaged in Pilot Projects

Name	RATE	FSN Level	Task 100			Task 107			Task 111			Task 113			Task 123			Task 124			Task 140		
			Cont.	Billed	Rem	Cont.	Billed	Rem	Cont.	Billed	Rem.	Cont.	Billed	Rem.	Cont.	Billed	Rem.	Cont.	Billed	Rem.	Cont.	Billed	Rem.
Achkasova, Alina	$55	9 S2																			30	30	0
Akulova Elena	$50														30	30	0						
Ananyeva, Galina	$55	9 S2																			79	50	29
Arventyeva Ludmila	$50														30	0	30						
Babarikina, Svetlana	$50	8 S3							$8 875	$8 875	1*)										98	98	0
Banin, Sergey	$100								$2 000	$2 000	2*)												
Belousov, Valery	$50																						
Belykh Svetlana	$45																						
Blagitko Yevgeny	$50														15	15	0						
Bocharov Yevgeny	$55														16	15	1						
Borodina, Anna	$50																						
Charlamova Olga	$40																						
Chernikov Sergei	$50														40	40	0	40	0	40			
Denisova, Larissa	$55	9 S2																			51	51	0
Dombrovskaya, Nadya	$30																						
Domnikova Natalia	$40														15	15	0						
Drachova Tatyana	$60														20	20	0	15	15	0			
Dyatchuk Vladimir	$50														15	14,5	0,5						
Efimova, Olga	$30																						
Freed, Edward	$55	9 S2																					
Fedchenko, Elena	$30																						
Fomin Grigory	$50														15	15	0						
Fomina Tatyana	$60																						
Gabdrakhimova, Tatyan	3000/d																						
Galitsky Boris	$55														9	9	0						
Gasanov, Yuri	$55	9 S2																					
Gerasimenko, Nikolay	$50																						
Goleva, Tamilla	$40																						
Gorshenev, Victor	$50																						
Gulbani, Larissa	$40	6 S11																					
Hadakova, Natalia	$55	9 S2				36	36	0															
Idolenko, Nina	$50																				25	25	0
Ignatenko Elena	$50																						
Isakova, Ludmilla	$60	9 S6				20	20	0															
Ivanchenko, Yulia	$40																						
Ivanova Lubov V.	$40																						
Ivanova Lubov K.	$50														15	15	0						
Ivanova, Tatyana	$20																						
Ivleva, Maria	$25																						
Izhboldina, Natalia	$30																						

Appendix 3: List of Russian Experts Engaged in Pilot Projects

		FSN	Task 100			Task 107			Task 111			Task 113			Task 123			Task 124			Task 140		
Name	RATE	Level	Cont.	Billed	Rem	Cont.	Billed	Rem	Cont.	Billed	Rem.	Cont.	Billed	Rem.	Cont.	Billed	Rem.	Cont.	Billed	Rem.	Cont.	Billed	Rem.
Kachanko, Natalia	$30																						
Khrapova Lubov	$50														15	14,5	0,5						
Kim Juri	$250/q																						
Kirilkina Galina	$50														45	45	0	60	60	0			
Kirichkov, Alexander	$50																						
Klynin, Sergei	$60	8 S3													20	20	0	20	20	0			
Kolosova Irina	$50														30	30	0						
Koroleva Irina	$50														15	14,5	0,5						
Korotkova, Anna	$50	8 S3	100	100	0																		
Kornilov, Vladimir	$50																				25	25	0
Kovrizhnykh, V.	$40																						
Kozirev, Nnikolai	$50																				25	25	0
Kravchenko Natalia	$50																						
Krasovskaya, Olga	$30																						
Kulik, Yuri	$60																						
Kurakin, Sergei	$55	9 S2																					
Kurakina, Elena	$50	8 S3																					
Lapina, Ludmila	$40																						
Lashukina, Ludmila	$30																						
Lebedeva, Nadezhda	$3 600																						
Leontieva, Veronica	$55	9 S2				36	36	0															
Malkov, Leonid	$100											40	32	8									
Mazera, Irina	$55	9 S2																					
Matveeva Natalia	$55																						
Melechova, Natalia	$55	9 S2																					
Melnikov Mikhail	$60														28	28	0						
Mesherjakova, Natalia	$20																						
Mezentseva Natalya	$40														15	15	0						
Mikhajlova, Julia	$50																						
Monastireva, Olga	$40																						
Morozova Galina	$50																				24	24	0
Murovanny, Alexander	$2 000								$2 000	2 000	2*)												
Nagornaya Irina	$55														15	15	0						
Nechaev Valery	$50														20	20	0						
Nechaeva Raisa	$50														20	20	0						
Nelepina, Natalia	$50	8 S3																					
Nesterov, Vladimir	$50	8 S3																					
Novikova, Natalia	$30																						
Ostrovskij, Viatcheslav	$2 000								$2 000	$2 000	2*)												
Oshkanova, Tatiana	$300	9 S2																					
Petrenko, Anna	$50	8 S3																					

Appendix 3: List of Russian Experts Engaged in Pilot Projects

		FSN	Task 100			Task 107			Task 111			Task 113			Task 123			Task 124			Task 140		
Name	RATE	Level	Cont.	Billed	Rem	Cont.	Billed	Rem	Cont.	Billed	Rem.	Cont.	Billed	Rem.	Cont.	Billed	Rem.	Cont.	Billed	Rem.	Cont.	Billed	Rem.
Petrova, Elena	$60																						
Petrova, Ludmila	$60																						
Pravada, Vera	$100																						
Prikhodko Arkady	$50														30	30	0						
Pykhalov, Alexander	$100																						
Romanchuk, Irina	$55	9 S2																					
Rudneva, Svetlana	$60																						
Sapronov, Fyodor	$2 000																						
Sedachjeva, Ludmilla	$55	9 S2				9	9	0							45	45	0				65	65	0
Shafronskaya, Galina	$55	9 S2																					
Shipachov, Konstantin	$55	9 S2																					
Shishkin Mikhail	$50														15	14,5	0,5						
Shorokhov Igor	$40														8	8	0						
Sintsova, Natalia	$55	9 S2													37	37	0	11	11	0	40	40	0
Slobodjanik Tamara	$55																						
Solostov, Anatoly	$50																						
Starkov Anatoly	$50														20	20	0						
Tarasov Nikolai	$55														28	28	0						
Tchernyavsky, Valery	$100		40	20	20																		
Temerkhanova, Larissa	$50	8 S3																			38	38	0
Tereshenko Andrey	$55														15	15	0						
Tomchuk Andrey	$40														9	9	0						
Trauter, Alexander	$50	8 S3																					
Tumannova, Svetlana	$101																						
Tzarik, Galina	$55	9 S2				9	9	0							77	77	0	33	33	0	20	20	0
Tzarik, Natalia	$50	8 S3																					
Ulanov, Alexei	$30																						
Urneva, Natalia	$50	9 S2				74	74	0															
Urneva, Tatiana	$55	9 S2				75	75	0															
Vidjakov Gennady	$50														20	20	0						
Vorobyov, Anatoly	$80											30	30	0									
Yanko, Alexander	$50	8 S3																					
Yegorova Iva	$60														20	20	0	15	15	0			
Zakirov, Anvar	$60	9 S6				36	36	0													8	6	2
Zelkovich, Roman	$60	9 S6				20	20	0															

Appendix 3: List of Russian Experts Engaged in Pilot Projects

Name	Task 141			Task 142			Task 143			Task 147			Task 149			Task 161			Task 164		
	Cont.	Billed	Rem.	Cont.	Billed	Rem.	Cont.	Billed	Rem.	Cont.	Billed	Rem.	Cont.	Billed	Rem.	Cont.	Billed	Rem.	Cont.	Billed	Rem.
Achkasova, Alina																					
Akulova Elena																					
Ananyeva, Galina																					
Arventyeva Ludmila																					
Babarikina, Svetlana							14	14	0												
Banin, Sergey																$2 000	$2 000	3*)			
Belousov, Valery				21	12	9															
Belykh Svetlana	60	60	0																		
Blagitko Yevgeny																					
Bocharov Yevgeny																					
Borodina, Anna	30	30	0																		
Charlamova Olga				25	20	5															
Chernikov Sergei				65	52	13															
Denisova, Larissa																					
Dombrovskaya, Nadya	10	10	0																		
Domnikova Natalia																					
Drachova Tatyana																					
Dyatchuk Vladimir																					
Efimova, Olga	10	10	0																		
Freed, Edward				10	0	10							20	20	0						
Fedchenko, Elena	10	10	0																		
Fomin Grigory																					
Fomina Tatyana	20	20	0													$3 000	$3 000	3*)			
Gabdrakhimova, Tatyan																$3 000	$3 000	3*)			
Galitsky Boris																					
Gasanov, Yuri							27	27	0												
Gerasimenko, Nikolay				21	20	1															
Goleva, Tamilla	15	15	0																		
Gorshenev, Victor																$500	$500	3*)			
Gulbani, Larissa							4	4	0												
Hadakova, Natalia																					
Idolenko, Nina																					
Ignatenko Elena																					
Isakova, Ludmilla							13	13	0												
Ivanchenko, Yulia				25	25	0															
Ivanova Lubov V.				25	25	0															
Ivanova Lubov K.																					
Ivanova, Tatyana	20	20	0																		
Ivleva, Maria	10	10	0																		
Izhboldina, Natalia	10	10	0																		

Appendix 3: List of Russian Experts Engaged in Pilot Projects

	Task 141			Task 142			Task 143			Task 147			Task 149			Task 161			Task 164		
Name	Cont.	Billed	Rem.	Cont.	Billed	Rem.	Cont.	Billed	Rem.	Cont.	Billed	Rem.	Cont.	Billed	Rem.	Cont.	Billed	Rem.	Cont.	Billed	Rem.
Kachanko, Natalia	10	10	0																		
Khrapova Lubov																					
Kim Juri																				######	4*)
Kirilkina Galina																					
Kirichkov, Alexander				21	12	9															
Klynin, Sergei																			######	######	4*)
Kolosova Irina																					
Koroleva Irina																					
Korotkova, Anna																					
Kornilov, Vladimir																					
Kovrizhnykh, V.	15	15	0																		
Kozirev, Nnikolai																					
Kravchenko Natalia				40	40	0															
Krasovskaya, Olga	10	10	0																		
Kulik, Yuri				20	20	0															
Kurakin, Sergei							10	10	0												
Kurakina, Elena							29	29	0												
Lapina, Ludmila	10	10	0																		
Lashukina, Ludmila				10	8	2															
Lebedeva, Nadezhda																$3 600	$3 600	3*)			
Leontieva, Veronica																					
Malkov, Leonid																					
Mazera, Irina							8	8	0												
Matveeva Natalia										8	8	0	6	6	0						
Melechova, Natalia							13	13	0												
Melnikov Mikhail																					
Mesherjakova, Natalia	10	10	0																		
Mezentseva Natalya																					
Mikhajlova, Julia				40	40	0															
Monastireva, Olga	20	20	0																		
Morozova Galina																					
Murovanny, Alexander																					
Nagornaya Irina																					
Nechaev Valery																					
Nechaeva Raisa																					
Nelepina, Natalia							58	58	0												
Nesterov, Vladimir							14	14	0												
Novikova, Natalia	10	10	0																		
Ostrovskij, Viatcheslav																					
Oshkanova, Tatiana																			######	$300	######
Petrenko, Anna							8	8	0												

Appendix 3: List of Russian Experts Engaged in Pilot Projects

	Task 141			Task 142			Task 143			Task 147			Task 149			Task 161			Task 164		
Name	Cont.	Billed	Rem.	Cont.	Billed	Rem.	Cont.	Billed	Rem.	Cont.	Billed	Rem.	Cont.	Billed	Rem.	Cont.	Billed	Rem.	Cont.	Billed	Rem.
Petrova, Elena	50	50	0																		
Petrova, Ludmila	50	50	0																		
Pravada, Vera																$3 000	$3 000	3*)			
Prikhodko Arkady																					
Pykhalov, Alexander																$2 000	$2 000	3*)			
Romanchuk, Irina							27	27	0												
Rudneva, Svetlana	50	50	0																		
Sapronov, Fyodor																$2 000	$2 000	3*)			
Sedachjeva, Ludmilla																					
Shafronskaya, Galina							10	10	0												
Shipachov, Konstantin							27	27	0												
Shishkin Mikhail																					
Shorokhov Igor																					
Sintsova, Natalia																					
Slobodjanik Tamara							13	13	0												
Solostov, Anatoly																$500	$500	3*)			
Starkov Anatoly																					
Tarasov Nikolai																					
Tchernyavsky, Valery																					
Temerkhanova, Larissa																					
Tereshenko Andrey																					
Tomchuk Andrey																					
Trauter, Alexander							13	13	0												
Tumannova, Svetlana																					
Tzarik, Galina																					
Tzarik, Natalia							20	20	0												
Ulanov, Alexei				10	8	2													######	######	4*)
Urneva, Natalia																					
Urneva, Tatiana																					
Vidjakov Gennady																					
Vorobyov, Anatoly																					
Yanko, Alexander							29	29	0												
Yegorova Iva																					
Zakirov, Anvar																					
Zelkovich, Roman							13	13	0												